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MEDICAL JOURNAL

PUBLISHED MONTHLY BY THE MEDICAL SOCIETY OF THE STATE OF NORTH CAROLINA

IN THIS ISSUE:

Symposium On Current Trends In Peripheral Vascular Surgery

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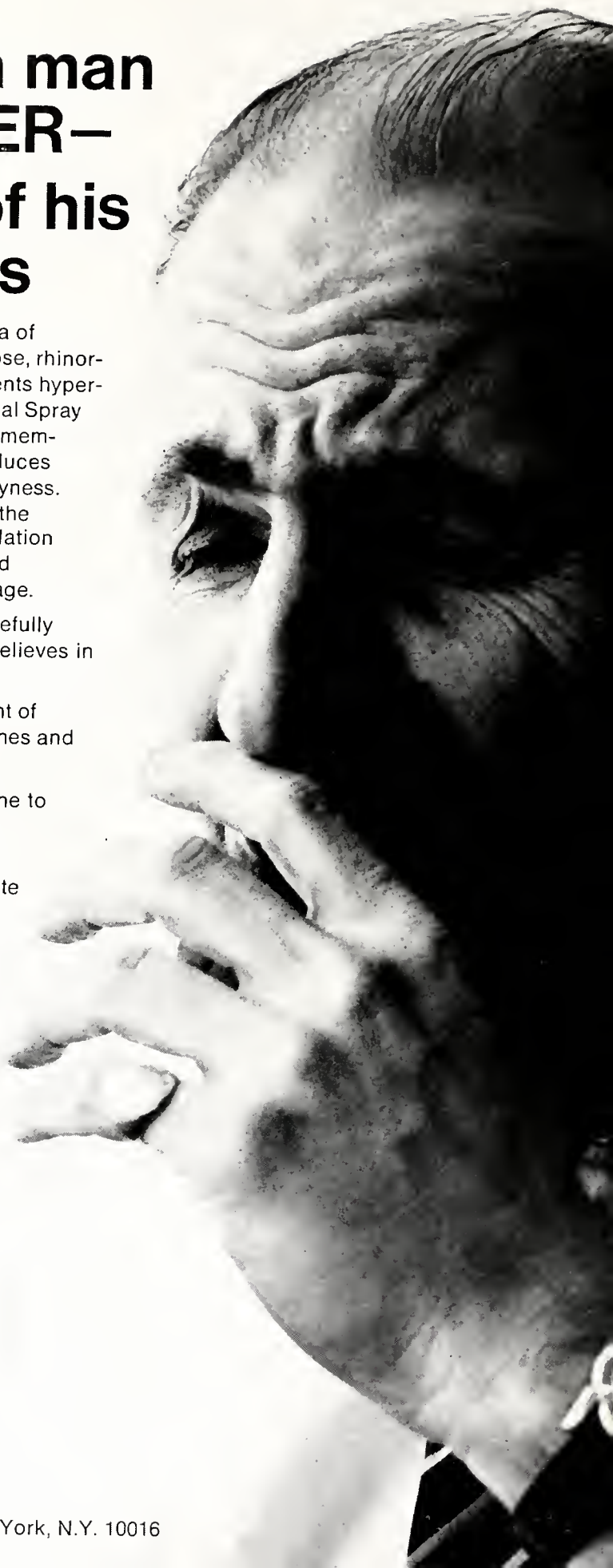
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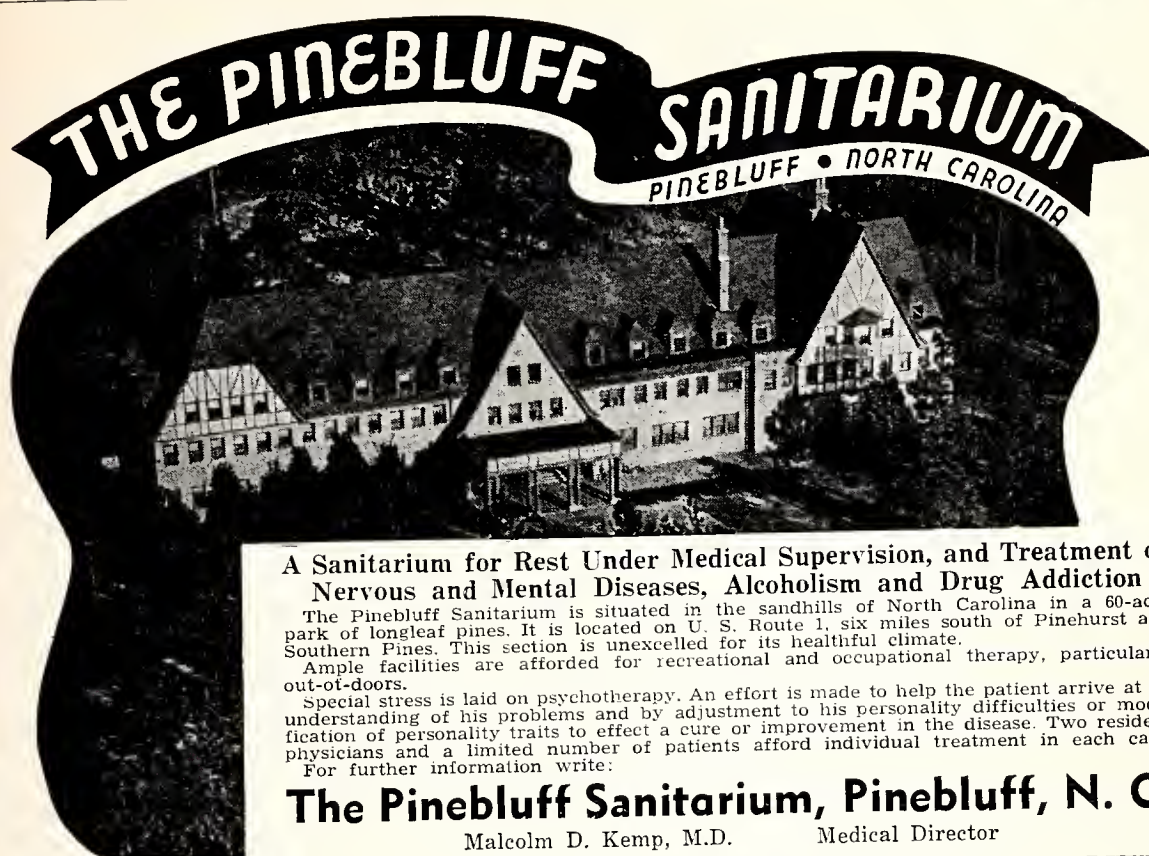
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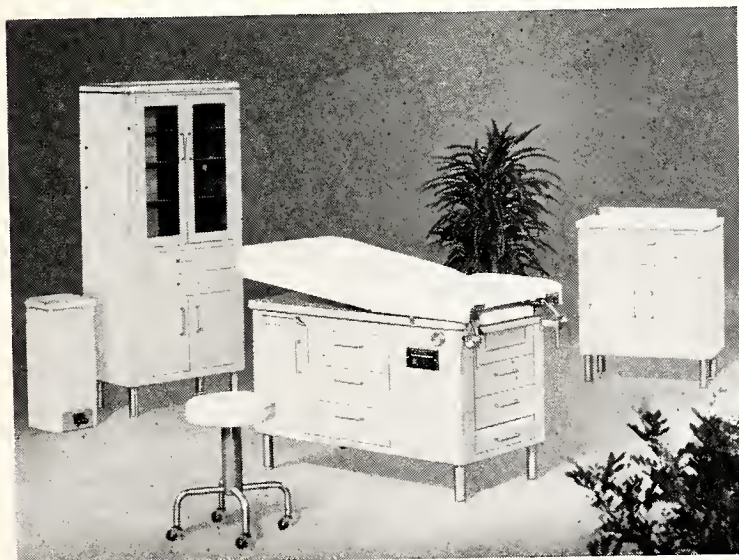
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Symposium On Current Trends In Peripheral Vascular Surgery Acute Venous Occlusion

JESSE H. MEREDITH, M.D.

WINSTON-SALEM

The phrase "acute venous occlusion" immediately suggests thrombosis within the veins of the abdomen, pelvis, and legs. This is because occlusions of other types and locations have very little clinical significance. Thus I shall similarly limit this communication, omitting the subject of chronic disease. Also, for clinical reasons I will classify occlusions as superficial and deep instead of following some of the older, more popular classifications.

Acute superficial thrombosis involves a tender, inflamed superficial vein (of the saphenous system), and compared to its brother—deep venous thrombosis—is a harmless phenomenon without long-term sequelae. *Deep thrombosis*, on the other hand, presents three serious threats: (1) production of emboli, (2) gangrene, and (3) significant long-term sequelae. In our management of this phenomenon we must keep these three threats in mind.

Diagnosis of deep venous occlusion is made by observation of a swollen and sometimes painful or tender leg. The thrombosis always extends considerably proximal to any swelling, so that swelling of the thigh is caused by iliofemoral venous occlusion.

Treatment

Treatment should be aimed at preventing emboli, necrosis of the leg, and long term sequelae (swelling, ulceration, etc.). Two

principal approaches are available: (1) containment of the clot and (2) removal of the clot. The rationale for containment of the clot is that acute intravascular thrombi are not static, but are constantly being dissolved (lysed) and re-formed on the surface; so if new clots can be prevented from forming, the total mass of a thrombus will spontaneously diminish. This is a slow process, and often does not occur before the clot has become organized and can no longer be lysed. The veins are then left full of organized clot. Recannulization may occur sometime later, but the fibrous remnant involves the valves, making them nonfunctional and causing the long-term (postphlebitis) syndrome we know so well. Containment is carried out by anticoagulation with heparin, Dicumarol, and more recently, dextran. I prefer heparin for this purpose, but will refrain from infringing on Dr. Silver's portion of the program.

It seems logical, then, that if the thrombus can be removed, this might be the most reasonable approach. It prevents embolization by removing the source (thrombus), it prevents gangrene by restoring the circulation, and it prevents the long-term sequelae by promptly restoring venous function and preserving the valve mechanism. Several clinics around the country have performed thrombectomy for acute venous occlusion, and reports of these series¹⁻³ have been favorable. The obvious objection to surgical removal of venous thrombosis is the risk of dislodging the clots and producing emboli; however, experience has shown this possibility to be much less a threat than originally thought.

Presented before the Section on Surgery, Medical Society of the State of North Carolina, Asheville, May 2, 1966.

From the Department of Surgery, Bowman Gray School of Medicine of Wake Forest College, Winston-Salem, North Carolina.

since embolization from this procedure is very rare.

Surgical techniques

Our procedure for venous embolectomy is as follows: The involved leg and groin are prepared and draped as a sterile field, with the leg encased in "stockinette." With the patient under local anesthesia, the common femoral artery and the common, deep, superficial, and saphenous veins are exposed and gently surrounded by heavy sutures. The artery is occluded by doubly surrounding it, with the suture pulled tightly and held by a hemostat. This reduces bleeding from the opened vein. The vein is then opened transversely, and while the patient performs the Valsalva maneuver, the clot, which is usually observed, is "teased" out from above and below. With a glass (drinking tube) suction tip the proximal and distal vein is suctioned free of clot, or the clots are removed by ballooned catheters.⁴ Free bleeding should occur from above when the valve, just in this area, is pushed open with an instrument. An Esmark bandage is applied to the foot, leg, and thigh to remove clots from the distal venous system. Often clots are limited to the vicinity of the venotomy. The artery

is then released in order to "flush" the distal vein, following which the venotomy is closed with 6-0 arterial suture and the wound closed.

Systemic heparinization should be carried out during the procedure and for four days thereafter. The swelling of the leg is reduced at the end of the procedure and is often completely gone within 24 hours. Ambulation should be encouraged from the day of operation.

Summary

Clinically significant acute venous occlusion occurs principally in the veins of the abdomen, pelvis, and legs. It can be treated by anticoagulation with heparin, Dicumarol, or by surgical excision (thrombectomy). I personally prefer the latter for reasons enunciated.

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* * *

Acute Arterial Occlusion

JOE W. FRAZER, JR., M.D., F.A.C.S.

GREENSBORO

New methods for the treatment of arterial emboli make a discussion of the problem of acute arterial occlusion very timely.¹⁻⁴ A new method of treating embolic occlusions described by Fogarty² is so simple that it can be applied in severe cases with little risk to the patient. Treatment of thrombosis is much more difficult and must be applied far more selectively. Thus the problem of accurate diagnosis prior to the application of proper therapeutic methods is even more important now than in past years. This problem will be the primary concern of the following discussion.

Diagnosis

In the large majority of patients the diag-

nosis of acute arterial occlusion is not difficult. A relatively sudden onset of pain, numbness, coldness, and paresthesia in the affected part are highly suggestive in themselves. If physical examination discloses pallor, collapsed veins, coldness, and absent pulses, it is certain that acute occlusion has occurred. To differentiate between the two major types of occlusion—that is, thrombosis or embolism—is at time more difficult, yet the two usually can be distinguished on purely clinical findings (Table 1).

If the onset of symptoms is instantaneous, we are more likely to be dealing with an embolus; yet embolism may produce mild symptoms initially, with acute pain appearing as

Table 1
Acute Arterial Occlusion

Symptoms	Signs
Pain	Pallor
Numbness	Absent pulse
Coldness	Coldness
Parenthesias	Collapsed veins

the clot extends distally. The past history may yield much vital information. A history of rheumatic heart disease, previous myocardial infarction, or some disturbance in rhythm is strong evidence for embolism. Of equal importance is a past history of intermittent claudication, indicating underlying arteriosclerosis. While emboli may lodge in diseased arteries or arise from the artery itself, arteriosclerosis is more often associated with thrombosis. Local trauma, polycythemia vera, and dehydration secondary to disease are also associated with thrombosis (Table 2).

Table 2
Etiology in 100 Consecutive Cases

	Embolism	Thrombosis
Heart disease	41	0
Cancer of the pelvis	2	0
Paradoxical	1	0
Arteriosclerosis	1	32
Postoperative	0	8
Buerger's disease	0	4
Infection	0	5
Miscellaneous	1	5

Additional information pertinent to the diagnosis is to be had from the physical examination. Table 3 indicates the preferential site of occlusion in thrombosis and embolism respectively. Obviously this is a relative matter; but it is true that embolism

Table 3
Preferential Anatomic Sites

Artery	Embolism	Thrombosis
Aorta	*	*
Iliac		*
Common femoral	*	
Superficial femoral		*
Popliteal	*	*
Subclavian		*
Brachial	*	

is more common in the terminal aorta and common femoral and brachial arteries, whereas thrombosis commonly occurs in the iliac, superficial femoral, and subclavian arteries. When all the foregoing factors are

considered, an accurate clinical diagnosis is possible in the majority of cases.

If additional proof is needed, arteriography may provide it. My personal preference is to omit arteriograms in cases thought to be embolic in origin. In questionable cases and whenever thrombosis is suspected, an arteriogram is vital to the choice of therapy.

Treatment

Treatment of acute arterial occlusion is based on the pathophysiologic findings. Symptoms and signs of acute arterial occlusion are a function of the size of the artery, the extent of collateral formation, the presence of spasm, and the status of the general circulation. The complete occlusion of a main artery immediately stops blood flow. Above and below the obstruction is a relatively static column of blood. The length of the column is governed by the presence of collaterals—that is, at the first good collateral, flow will be possible. It is in the area of stasis that clotting occurs. As the clot extends, additional collaterals are occluded, resulting in more ischemia. Associated spasm aggravates this phenomenon. Prevention of propagating thrombus at and below the initial obstruction is a vital part of therapy. Immediate anticoagulation with heparin should be instituted and maintained.

The second phase of treatment is the restoration of flow by removal of the obstruction. This measure may be necessary immediately or it may be delayed. This decision is of the utmost importance in treating acute occlusions.

In general, I feel that all peripheral emboli should be removed when diagnosed. The method of choice is that described by Fogarty. Of all the recent advances in cardiovascular surgery, the balloon catheter is the most useful. It is usually successful when properly applied. Emboli as well as propagated clots can be readily extracted under local anesthesia with little damage to the artery and no harm to the patient. The only exception might be the embolus that has been present for many hours, in which case irreversible ischemic changes have already appeared. For years various authors have

tried to establish time limits after acute occlusion which would preclude operation, but it is the viability of the limb that determines operability. The time to operate on peripheral emboli is as soon as the diagnosis is established, provided frank gangrene and rigor mortis have not appeared.

Thrombosis and embolism present entirely different pictures from the surgeon's point of view. The Fogarty catheter is useful in extracting a propagated clot distal to a thrombosis, but is of little value in permanently removing the clot itself. Embolism is more often associated with relatively normal arteries, whereas thrombosis is usually found in diseased or damaged vessels that must themselves be treated in order to re-establish flow. Much the same indications and methods advocated for chronic vascular occlusive disease apply to thrombosis. The patient presenting with severe ischemia but a viable extremity that responds to heparin can usually await definitive treatment long enough for the surgeon to evaluate his problem. This is very important in view of the magnitude of many of the surgical procedures that may be required.

Severe ischemia progressing toward gangrene warrants surgery unless the general condition prohibits it. Severe but nonprogressive ischemia in very poor risk patients requires anticoagulation therapy and observation, in the hope of avoiding surgery. Severe ischemia in good risk patients, particularly the younger ones, should be treated by corrective surgery as soon as is reasonable. Indications for surgery in mild to moderate degrees of ischemia are matters for individual judgment based on the patient's age, general physical condition, need for physical activity, and the chance of obtaining a good result.

Choice of operative procedures includes all the techniques of vascular surgery which are discussed in this symposium. My own preference is for endarterectomy, with venous patch grafts as needed for shorter segments. Saphenous vein by-pass grafts are chosen for the more extensive lesions. A third choice is the Dacron prosthesis. We prefer to limit its use to areas above the inguinal ligament.

The final phase of therapy concerns the prevention of recurrence. Any patient who suffers from an arterial embolus is a candidate for permanent anticoagulation therapy. In rheumatic disease, correction of the valvular lesion with atrial appendectomy has been used as a reason for discontinuing this medication. I feel strongly that it should be maintained. Certainly embolization from a mural thrombus is absolute indication for permanent anticoagulation. Problems of thrombosis do not require anticoagulation beyond the brief postoperative period except in those cases associated with "vasculitis" in which we fear thrombosis at other sites in the arterial tree.

Personal Experience

Since the Fogarty catheter became available to me in late 1963, we have had occasion to use it in treating 16 patients with arterial emboli. In all but one, normal flow was established in the large vessels, but perfusion was inadequate and thrombosis occurred. There have been three cardiac deaths following embolectomy, including the case just mentioned. In addition, the balloon catheter has made the handling of other peripheral vascular problems easier. We have had occasion to remove distal thrombi after proximal occlusion; to extract fresh distal clots after crossclamping iliac arteries; to remove propagated thrombi in traumatic cases; and finally to dilate very small vessels prior to anastomosis. The Fogarty catheter is available in our operating room in every cardiovascular case.

Our personal experience with acute thrombosis is more difficult to evaluate. Our policy is to apply corrective surgery in the same manner that we would use in dealing with chronic occlusive problems. Attempts simply to remove the thrombus are fraught with failure; the fundamental cause of thrombosis must be corrected if cure is to be achieved. The specific methods and results are discussed elsewhere in this symposium.

Summary

A discussion of problems in the diagnosis and treatment of acute arterial occlusion is

presented. The Fogarty method of treating emboli is emphasized. My personal experience with this method is recounted.

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* * *

Penetrating Vascular Injuries

HORACE G. MOORE, JR., M.D.

WILMINGTON

Until recently there was a popular misconception that few patients with penetrating arterial injuries survive to reach surgical care. We now know that survival depends upon many factors, including the nature and extent of the wound, the ability of the surrounding tissues to induce the stoppage of bleeding, and the availability of blood replacement.

Penetrating arterial injuries fall generally into two categories: (1) incised wounds, and (2) wounds caused by missiles.

The management of incised arterial wounds is simple and straightforward. If the wound is transverse or oblique, simple suture will usually suffice. If transection is complete, end-to-end anastomosis is indicated. In these instances there is usually no loss of vessel. If the laceration happens to run longitudinally, simple suture will cause narrowing of the lumen. In order to prevent loss of diameter, closure must be effected with a patch graft, or the injured segment must be resected and repaired by anastomosis or replacement with a graft.

Unfortunately the situation is not so simple in the management of arterial wounds caused by missiles.

In May, 1952, I explored the abdomen of a 14-year-old girl approximately six hours after she had shot herself with a .22 caliber rifle. In addition to multiple visceral injuries, there were two eccentrically located holes measuring 0.4 cm in the right side of the abdominal aorta. The two holes were separated by a thin bridge of aortic tissue, and the margins of the defects were finely ragged. The bridge of tissue and the ragged protrusions were debrided, thus converting the smaller defects into a single lesion 1 cm

in diameter. This defect was then closed transversely and good hemostasis was immediately established. On the twenty-second postoperative day the patient began to pass bloody material by rectum, and on the twenty-fourth day she went into shock and died during surgical re-exploration. A complete protocol of this case has previously been reported.¹

It is unfortunate that the initial success in the management of this patient should turn to ultimate failure. There obviously were technical inadequacies which needed elucidation, and it was this consideration that stimulated my colleagues and me to study gunshot wounds of arteries experimentally. The result of our work has been reported in detail.^{1, 2} Some of its more significant features will be reviewed in this paper.

We set out to answer the following questions: (1) What is the nature and extent of gunshot wounds of arteries? (2) How much debridement is necessary? (3) What is the best method of reconstruction?

Nature and Extent of Injuries

Anesthetized adult mongrel dogs were used in this study. Because of vessel size, only the thoracic or abdominal aorta was shot. Three types of missiles were evaluated as shown in Table 1.

Table 1
Specifications of Missiles

Caliber	Weight (grams)	Muzzle velocity (ft/sec)	Kinetic energy ($E=1/2mv^2$)
.177	.67	180-500	1.62×10^4
.22 short	1.93	1125	122×10^4
.22 long rifle	2.67	1335	231×10^4

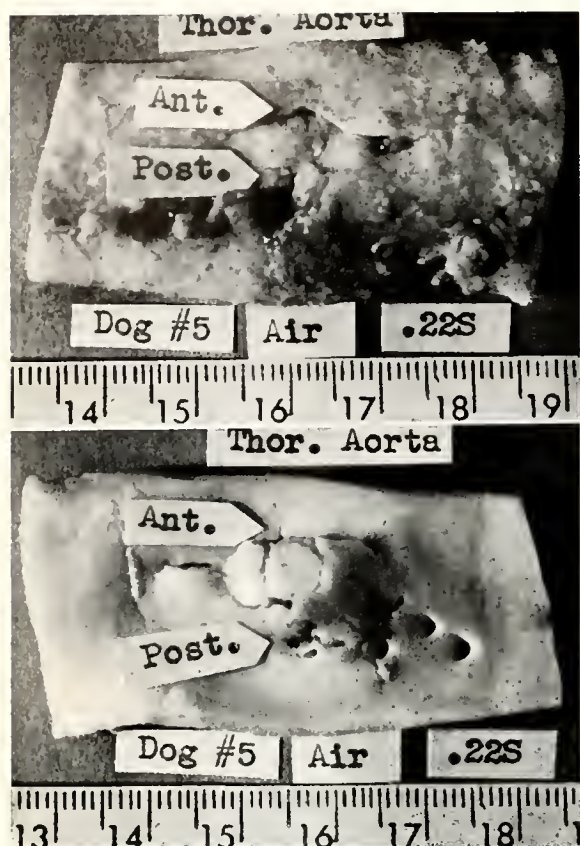


Fig. 1. Photograph of a normotensive thoracic aorta shot with a .22 short-rifle when exposed to air. (A) External, and (B) internal view. There is extensive communication, and the intimal damage is more extensive. (From Moore et al.²)

It is seen that the range of energy is great—that is, the .22 caliber long-rifle missile has about 143 times the energy of the .177 caliber missile.

We were initially puzzled and discouraged when we tried to reproduce a clinical type of injury. Figure 1 shows a normotensive thoracic aorta exposed to air and shot with a .22 short-rifle missile. The comminuted injury was out of all proportion to the clinical injury previously described. The 16 dogs in this group were shot with either a .177 or .22 caliber short-rifle missile. All injuries were comparable to that shown in Figure 1. An important feature to be noted is that the intimal damage was more extensive than that viewed from the adventitial side of the artery.

Further frustration was encountered in attempts to reproduce clinical injuries by

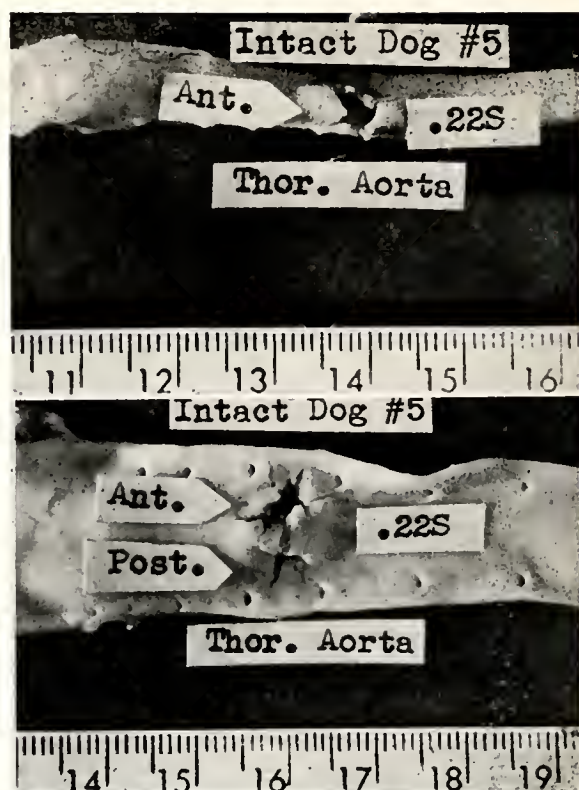


Fig. 2. Photograph of a normotensive thoracic aorta injured with a .22 short missile in an intact animal. (A) External, and (B) internal view. (From Moore et al.¹)

shooting the aorta in the intact anesthetized animal. Finally two aortas were hit out of five tries, and one of these is shown in Figure 2. The extent of the injury was less than incurred when the vessel was exposed to air and shot, and was closely comparable to the clinical injury. It should also be noted that the extent of intimal damage was greater than that of the externally observed wound.

It occurred to one of us that clinical injuries might be obtained by shooting the exposed vessel under a shallow layer of normal saline. This seemed to be a reasonable expedient, since the surrounding tissues apparently play some role in determining the extent of injury, and since the density of normal saline approximates that of body tissue. Sixteen aortas were covered with a shallow layer of saline and shot. Figure 3 shows one of the typical injuries in this group. The injuries here simulate clinical injuries. Again it should be noted that the

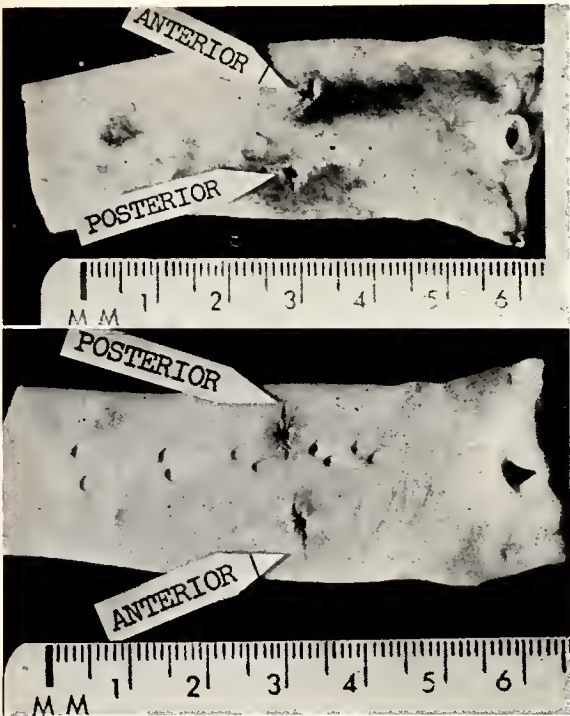


Fig. 3. Photograph of a normotensive thoracic aorta shot with a .22 long rifle missile while covered with a shallow layer of saline. (A) External, and (B) internal view. (Taken from Moore et al.¹)

gross intimal damage exceeds that observed externally.

Harvey and others³⁻⁵ have shown, in an ingenious group of experiments, that tissue damage in high-velocity missile wounding is the result of tissue displacement by the cavity which follows in the wake of the missile. No tissue damage is caused by the shock wave (Fig. 4). With reference to missile injuries to blood vessels, the resultant damage is directly related to displacement of the wall beyond the tensile tolerance

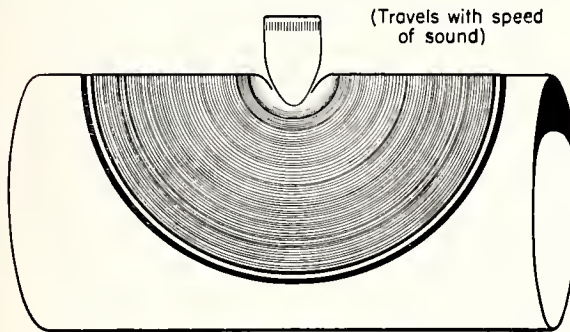


Fig. 4. Diagrammatic representation of "shock wave" (unimportant in blood vessel injury). (From Moore et al.¹)

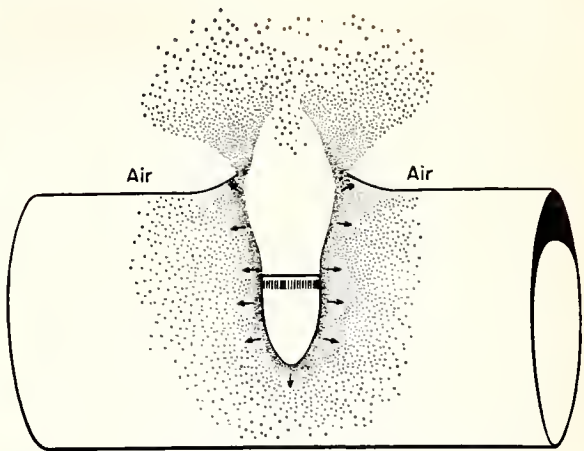


Fig. 5. Diagram showing unopposed displacement of vessel wall by cavity and transmitted energy when vessel is exposed to air. (Taken from Moore et al.¹)

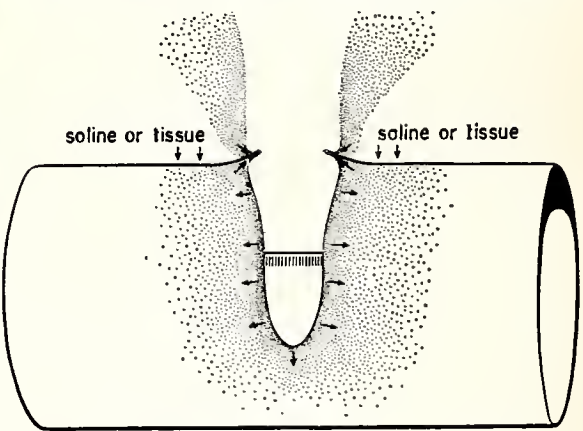


Fig. 6. Diagram showing opposite pressures on the two sides of vessel wall when exposed to saline or tissue at time of injury. Pressures cancel each other and minimize displacement of wall. (From Moore et al.¹)

of the wall. This displacement is caused by the temporary cavity following in the wake of the missile, in addition to the projection area of the missile. In the instance of vessels wounded while exposed to air, the damage was extensive because there was no balancing of pressures on the two sides of the vessel wall (Fig. 5). When the vessel was exposed to tissue or saline, the pressures of the temporary cavity balanced each other on the inside and outside of the walls, causing minimal displacement (Fig. 6). The latter consideration explains the less extensive clinical injury observed in the intact animal or when the artery was covered with normal saline. It is also because of this cancellation of opposing pressures that little difference

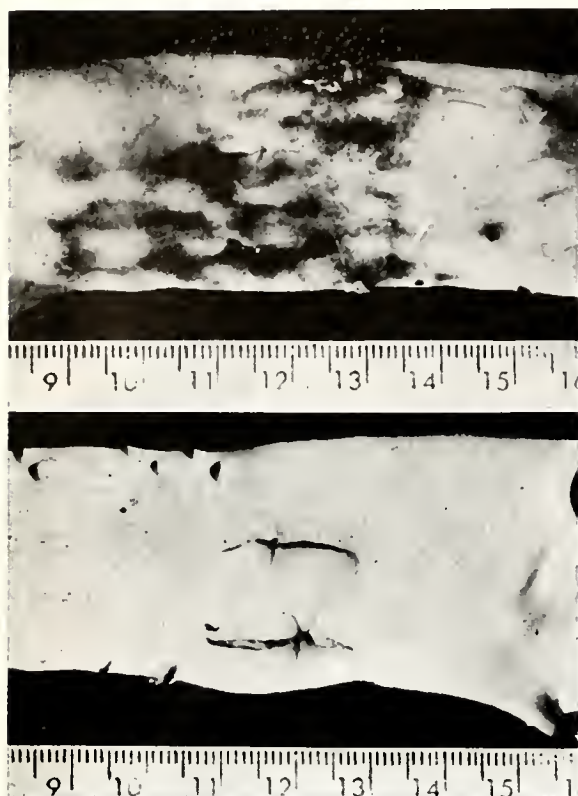


Fig. 7. Photograph of hypertensive (B. P. 200/130) thoracic aorta shot with .22 short missile under saline. (A) External, and (B) internal view. (Taken from Moore et al.¹)

was noted between wounds due to the .22 short and .22 long rifle missiles.

In order to test this hypothesis of the mechanism of wounding, four dogs were made hypertensive by an infusion of norepinephrine at the time of shooting the aorta under saline. Figure 7 shows an example of the more extensive wounds seen in this group. Because of hypertension, the vessel walls were already displaced somewhat and had less residual tensile tolerance than their normotensive counterparts. Again intimal damage was greater than the apparent external damage.

Debridement

Most of the arterial wounds in this study were evaluated microscopically. It was consistently observed that microscopic fragmentation extended no farther than 3 mm beyond the gross internal damage, regardless of which of the three missiles was used. Therefore, debridement must extend in all directions at least this far beyond the gross



Fig. 8. Photomicrograph of aortic repair of patient. Note extensive fragmentation. Intimal side is up. Hematoxylin and eosin stain. X 23. (Taken from Moore et al.¹)

internal defect if sutures can be expected to hold. Figure 8 shows the margin of the sutured defect in the patient described earlier. Obviously debridement was inadequate.

Reconstruction

In the instance of eccentrically located arterial wounds, it is tempting to debride an adequate wedge of the vessel wall and reconstruct continuity by a partial transverse suture line. This method invariably leads to angulation of the artery and resultant distortion of flow. Thrombosis may occur as a result of the disturbed flow pattern, an example of which is seen in Figure 9.

We found the most satisfactory type of repair in all respects is segmental resection and anastomosis such as that seen in Figure



Fig. 9. Photograph of thoracic aorta from dog dying 16 days after wedge debridement and transverse repair. Note sacculation and resultant thrombus arising from suture line. (Taken from Moore et al.¹)

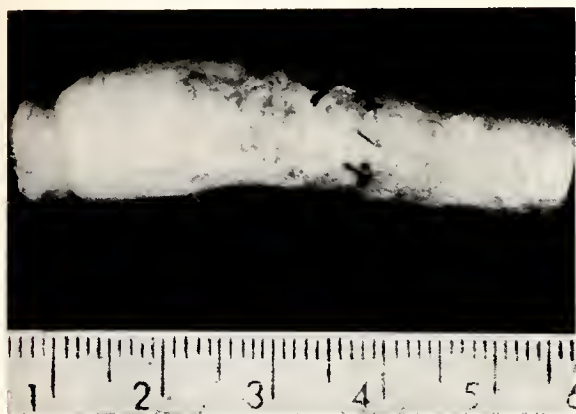


Fig. 10. Photograph of repair of thoracic aorta shot with .22 short missile under saline. Debridement was by segmental resection. Removed on 153rd day and inflated to 120 mm. of mercury with air. (Taken from Moore et al.¹)

10. An additional advantage of this method is that the average occlusion time was 4 1/2 minutes less than that associated with wedge excision and closure.

Discussion

Immediate exsanguination is not an invariable consequence of perforating injuries of major arteries. There are many reported instances of survival to surgical treatment of such injuries in both the civilian and military literature. Witness the frequency with which the patient with a ruptured aneurysm of the abdominal aorta may bleed for 12 to 48 hours and still be salvageable.

Fortunately the nature and extent of clinical arterial gunshot wounds caused by the missiles studied in this work are amenable to surgical repair. The degree of arterial damage depends on the extent to which displacement of the vessel wall exceeds the tensile tolerance of the tissue. Hypertensive or arteriosclerotic arteries will suffer more extensive damage than will normotensive non-sclerotic vessels.

In the range of missiles studied in this work, adequate debridement may be achieved by removing at least 3 mm of artery beyond the gross intimal wound margin. This may readily be determined by retracting the edges with a nerve hook and inspecting the intima. Rapid hemostasis may be achieved without occlusion of flow by finger pressure over the defects while the artery is being freed. Then arterial clamps may be

applied, and resection with anastomosis or implantation of a graft or prosthesis may be rapidly performed. In the case of injury to the abdominal aorta, it is important to cover the repaired defect with peritoneum as a protection against formation of an aortoenteric fistula.

Conclusions

1. Many patients with penetrating arterial injuries *do* reach surgical care in time to be helped.

2. Incised wounds may be repaired with either transverse closure, anastomosis, or longitudinal closure with a patch.

3. The defects produced by missile injuries to arteries depend upon: (a) the projection area of the missile, and (b) the degree to which the displacement of the wall exceeds the tensile tolerance of the tissue.

4. Gross intimal damage always exceeds apparent external damage.

5. Microscopic fragmentation usually extends no farther than 3 mm beyond the gross intimal defect.

6. Transverse closure after partial circumferential excision of the wall results in angulation of the vessel, sometimes causing thrombosis at the site of repair.

7. The optimal type of debridement and repair is resection of the injured segment at least 3 mm beyond the gross intimal defect, followed by anastomosis or graft replacement.

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Femoropopliteal Obstruction

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OTTEEN

Obstructive arterial lesions of the lower extremity continue to challenge the surgeon's judgment and technical ability. Early enthusiasm for direct arterial reconstruction in this area has been tempered by the high incidence of failure in small-vessel surgery. Failures result not only from technical limitations, but also from the diffuse and progressive nature of the disease so frequently encountered. Fortunately, better selection of patients, greater understanding of the natural history of atherosclerosis and improvement in surgical techniques provide a basis for optimism.

Femoropopliteal occlusive disease causes gangrene, rest pain, and claudication. Gangrene and rest pain indicate severe ischemia, and treatment is nearly always surgical. Claudication, if not severe, may require only conservative, non-surgical management.

Selection of Patients

No evaluation of peripheral vascular disease is complete without arteriography. This is a procedure of minimal risk and discomfort. Although the specific technique employed will be the one most readily adapted to available equipment, multiple serial x-ray exposures of both lower extremities should be obtained, spanning an area from the abdominal aortic bifurcation to the popliteal trifurcation.¹ Visualization and evaluation of the arterial inflow as well as outflow are essential. Since arterial flow varies considerably, not only are multiple exposures usually necessary, but some method of timing and determination of flow rate is helpful. Should initial films fail to show the distal circulation, the arteriogram can be repeated with proper adjustment of the exposure times.

A patient's major difficulty may be in the very small peripheral arteries. More specialized radiographic techniques are needed

to demonstrate these abnormalities. With the aid of radioisotopes (Fig. 1), circulation time to the area of investigation can be accurately determined and x-ray exposure

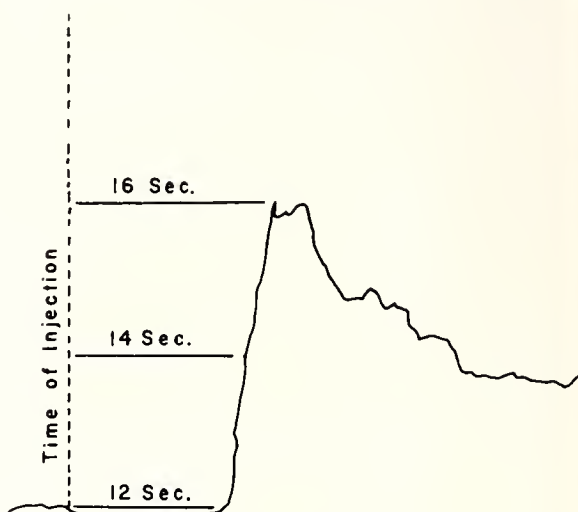


Fig. 1. Circulation time to the foot determined by injecting RISA (^{131}I) through the angiographic needle prior to an injection of contrast medium. A 1-inch probe is placed over the posterior tibial artery, and the time delay required between injection and x-ray exposure is thus determined.

time planned. Radiographic magnification² has been helpful in visualizing these finer vessels. Small focal-point x-ray tubes should be used to avoid distortion. Digital arteries as small as 0.3 mm can be seen clearly by this technique.

While a careful examination of the extremity and arteriography may be quite adequate for diagnosis, other procedures are valuable in determining the extent of disease as well as demonstrating the effects of treatment. Such procedures include the recording of skin temperature, oscillometry, ergometry, plethysmography, sweating tests, skin conductivity, and radio-sodium clearance tests. A peripheral vascular laboratory complete with a constant temperature room and equipment for these studies is certainly ideal, but the lack of these facilities does not preclude good surgical management.

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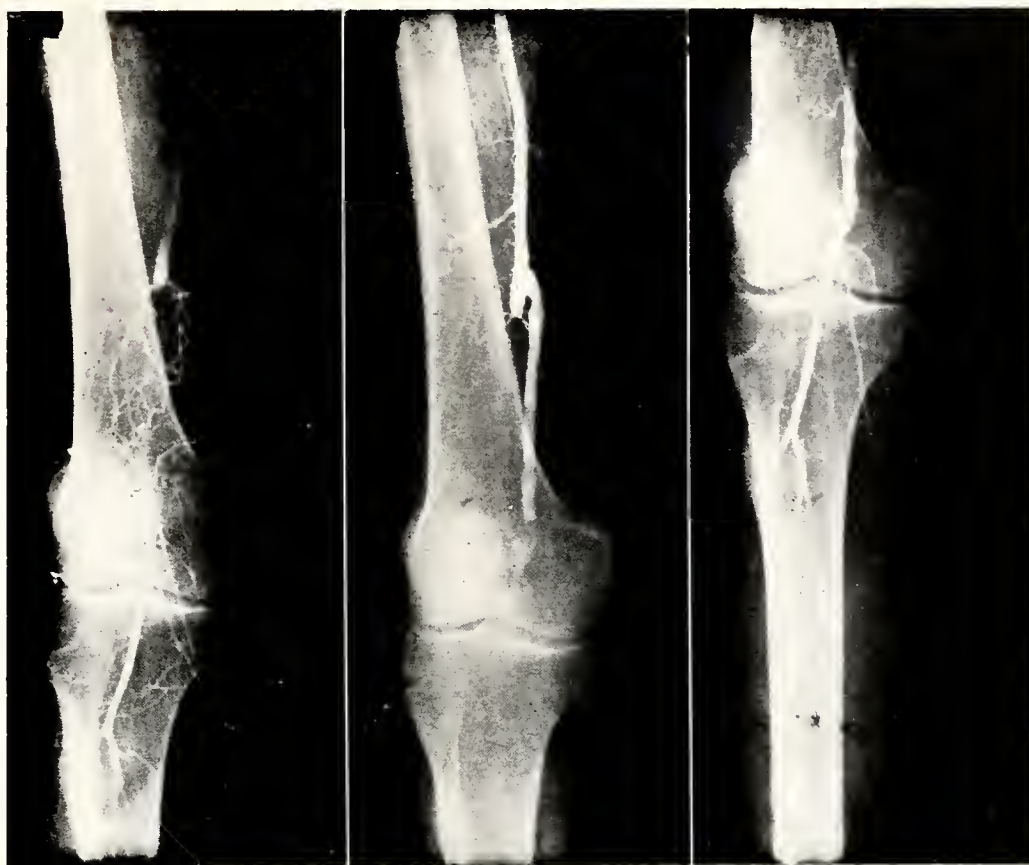


Figure 2

A (left). Preoperative angiogram showing occlusion of the superficial femoral artery.

B (center). Postoperative angiogram showing proximal anastomosis of saphenous vein to femoral artery. Two valves can be seen in the reversed segment of the vein.

C (right). Postoperative angiogram showing distal anastomosis of saphenous vein to popliteal artery.

Treatment

Sympathectomy

Lumbar sympathetic denervation will prevent vasoconstriction in the skin and digits of the lower extremities. It will not augment muscle blood flow and will not, therefore, relieve claudication. Furthermore, it is unlikely that sympathectomy significantly aids in the development of collateral circulation.³ These observations do not detract from the value of sympathectomy used alone or in combination with arterial reconstruction. By preserving the skin with the aid of sympathectomy, gangrene and amputation may be averted and time gained for development of collaterals by natural stimuli.

Arterial reconstruction

The autogenous vein was the initial graft used for arterial reconstruction.⁴ Its lack

of wide acceptance was due to the limited experience and poor results associated with early vascular surgery. Homografts and synthetic prostheses led to wider use of peripheral vascular surgery and provided the needed experience. Now after many clinical and experimental trials of the various prostheses, the saphenous vein (Fig. 2) has regained its status as the best graft for small artery surgery.

One of the original disadvantages of the vein graft remains. Most surgeons find that approximately 20% of patients lack a suitable vein for grafting—that is, one of sufficient length and caliber (5 mm or more in its smallest diameter).

Because the saphenous vein contains valves, it is necessary to reverse the excised vein to accommodate the arterial flow. This places the smallest diameter of the

vein in the proximal anastomosis. To avoid this situation and to limit the venous dissection and trauma, in situ vein grafts have been recommended.⁵ Only enough of the proximal and distal vein are dissected free to allow approximation and anastomosis to the artery. The valves are rendered incompetent by intraluminal rupture. Communicating veins are detected by arteriography and ligated to prevent the formation of arteriovenous fistulas. This procedure probably deserves further evaluation.

Endarterectomy is particularly suited for the short segmental occlusion. To prevent surgical stenosis, the lumen may be enlarged by a patch graft. Again autogenous vein makes the most satisfactory graft, although synthetic grafts and fascia have been used. One should be cautioned against using thin-walled, visceral veins for this purpose. Peripheral veins, and particularly the saphenous, are thick-walled and capable of withstanding arterial pressures. Results of endarterectomy and venous patch tend to be somewhat less successful than the venous bypass. This is probably because the segmental occlusion is not always as well localized as anticipated.

Regardless of the graft or procedure employed, there should be good pressure and flow into the area of reconstruction. If mul-

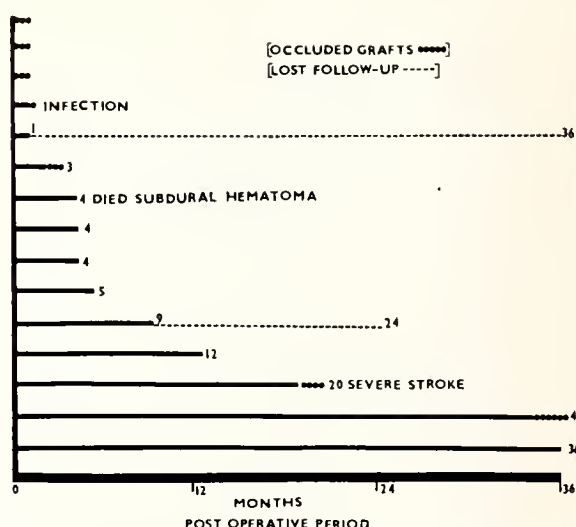


Fig. 3. Results of 15 saphenous vein bypass grafts showing three early failures, two of which were due to technique and one the result of an inadequate vein. Two patients are lost to follow-up, and there have been three late occlusions.

tipple obstructive lesions are present, relief of the most proximal occlusion may be effective.

During surgery, systemic heparin, 1 mg./kg., is sometimes helpful, especially if there have been previous episodes of acute or sudden thrombosis. Occasionally, because of technical difficulties or because of poor arterial flow, intravascular clotting may be a problem. Operative angiography can demon-



Figure 4

- A (left). Ischemic ulceration of foot prior to saphenous vein bypass.
 B (center). Healing of ischemic ulcer following successful saphenous vein bypass graft.
 C (right). Recurrent gangrene of toes incident to thrombosis of vein bypass graft 18 months after operation. Note complete healing of dorsum of foot.

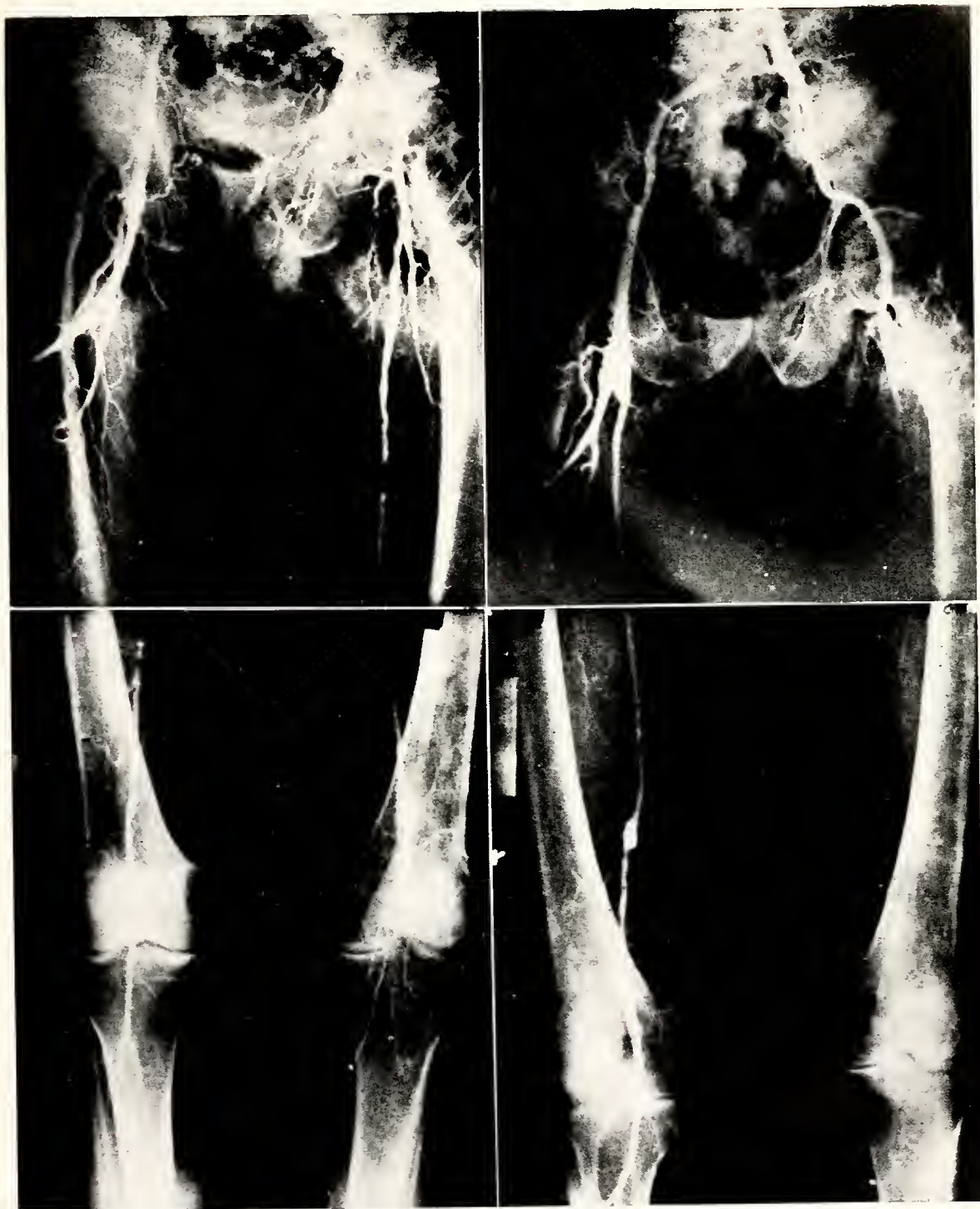


Fig. 5. (Same patient as represented in Figure 4).

A (left). Preoperative angiogram of patient with ischemic ulceration of the dorsum of the foot, showing complete occlusion of the superficial femoral artery.

B (right). Angiogram of long saphenous vein bypass graft in same patient.

strate an anastomotic defect. Such defects should be corrected as soon as detected. The Fogarty Balloon Catheter is useful for removing propagated clot.⁶

The immediate results of arterial reconstruction will be successful in 80% to 90% of the patients with saphenous vein grafts (Fig. 3) and somewhat less so when en-

arterectomy or Dacron grafts are used. Progression of atherosclerosis in the legs as well as in the heart and brain can be anticipated. In fact atherosclerotic plaques have been seen in the pseudo-intima of a Dacron graft⁷ and in the walls of vein grafts.⁸ The fact that arteriosclerosis is a generalized and progressive disease should not discourage consideration of active surgical intervention. The healing of ischemic ulcers and gangrene is dramatic when surgery is successful (Fig. 4), and six months or six years of relief from pain is certainly worthwhile.

Comment

Even though the autogenous saphenous vein has contributed much to the improvement of small vessel surgery, it is inconvenient and sometimes difficult to use. It is not surprising, therefore, that the search continues for a better arterial substitute. Homografts have been disappointing, resulting in a high incidence of late thrombosis and aneurysm formation. Heterografts are subject to the same disadvantages. A synthetic graft is the logical goal. The ideal

prosthesis may eventually be conceived through a better understanding of the basic problem of intravascular thrombosis.

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Adjuncts to the Surgical Treatment of Peripheral Vascular Disease

A Review and a Preliminary Report on Urokinase

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Even though the vascular surgeon has become skillful in the operative management of occlusions in large and small vessels, he is still frequently confronted with the need for adjuncts to maintain vessel patency and blood flow. Furthermore, he not infrequently finds himself managing vascular occlusions by non-operative means in patients on whom, for various reasons, surgery is not indicated. Although this report will review experiences with some of the medical adjuncts for establishing and maintaining ves-

sel patency, it must be emphasized that at present patency of major vessels is best re-established by surgical means: adjuncts may or may not be needed to maintain the patency.

A multitude of chemical agents have been proposed to inhibit clotting or to lyse clots. The majority have little or no therapeutic effect. The best agents available for preventing thrombosis and maintaining the fluidity of the blood are heparin and the dextrans; the best available agent for lysing thrombi is Thrombolysin*, a plasmin preparation. Experience with these agents

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will be reviewed and preliminary experience with urokinase, a new potent plasminogen activator, will be presented.

Heparin

Heparin is the most potent and reliable anticoagulant drug available today. It was discovered in the dog's liver in 1916¹ and subsequently was found to be a mucopolysaccharide having a molecular weight of approximately 16,500. It originates in the mast cells and is widely distributed throughout the body tissues. Because of its sulfaminic linkage (a sulfate group bound to an amino group), heparin has a strong negative electric charge which causes it to interfere with almost any reaction in which proteins are involved. Investigations^{2, 3} have shown that it possesses antithrombotic, antiprothrombic, and antithromboplastic effects. It also has a lipemic clearing effect and will inhibit the release of serotonin. Heparin is mainly metabolized in the liver; however, about 20% to 25% of injected heparin is excreted via the urine.

I use heparin routinely to prevent thrombosis or rethrombosis during and after vascular surgery, and also to prevent the extension of thrombosis in patients who have not been operated upon.

1. Use during vascular surgery

Heparin is administered intravenously by the anesthesiologist during most vascular operations after the appropriate vessels have been isolated, but at least one minute before they are clamped. The usual dose for the average adult is 50 mg given intravenously. Special efforts must be made to maintain virtually perfect hemostasis before the drug is administered and throughout the remainder of the operation. If a woven Dacron graft is to be inserted, it is preclotted with blood obtained before the heparin is given. If it is necessary to keep the vessels occluded for a long period, additional heparin, usually half the initial dose, is given at two-hour intervals.

After the operation the patient is placed on a regimen of heparin given subcutaneously every four hours. A clotting time is obtained three and one half hours after a dose of heparin has been administered, and

the next dose is so regulated as to maintain a clotting time approximately three times the control. The optimal range is 20 to 25 minutes.

If there is excessive oozing or frank bleeding at the end of the operation, six to eight hours may be allowed to elapse before the subcutaneous administration of heparin is begun. Usually a very light dressing or none, is applied, and the patient is carefully observed for hematoma formation. If the clotting time is maintained within the 20- to 25-minute range, hematomas rarely occur. After five or six days of heparin therapy, the dosage is tapered by 10 mg per dose until the drug is discontinued.

2. Use to prevent the extension of thrombosis

A control clotting time is obtained, and then 75 mg of aqueous heparin is given intravenously for the average man weighing 70 kg. If the patient weighs more than 70 kg or has a markedly shortened clotting time, a larger dose (usually 100 mg) is given. If the clotting time is prolonged or the patient weighs less than 70 kg, less heparin is given. A clotting time is determined in three and a half hours, and the patient is then given heparin subcutaneously every four hours. The dosage given is selected to maintain the clotting time between 20 and 25 minutes, three and a half hours after the preceding dose.

With the dosage of heparin carefully regulated to maintain the clotting time in the appropriate range, complications have been minimal. Should excessive bleeding or hematoma formation occur, or should an operation be required while the patient is receiving heparin, the drug can be readily neutralized with protamine sulfate on a milligram for milligram basis. Occasionally, 1.5 mg of protamine sulfate is required for each milligram of heparin.

Heparin is contraindicated in patients who are about to undergo surgical procedures (once the operation has been begun and hemostasis obtained, the drug may be administered safely), and during spinal puncture, because of the large dural veins which may be injured. Prolonged use of heparin

has been incriminated as a cause of decreased renal function, and has also been associated with osteoporosis.¹

Dextran

Dextran is the name first used to designate the gums of carbohydrate nature forms in the juices of sugar beets, wine, and other food products. Dextran is a polyglucose with the empirical formula $(C_6H_{10}O_5)_n$, which may be produced by the action of a number of microorganisms on carbohydrates. It is not a well defined substance, and its properties vary greatly.

The crude, ungraded dextrans have molecular weights in the tens of millions, and consist of very large branching, flexed molecules. Some of these molecules are large enough to produce occluding emboli in arterioles and capillaries. By the use of strong acid hydrolysis (pH 1) under controlled temperatures, these dextrans may be broken into small molecular units. After neutralization of the acid, the dextrans are precipitated with alcohol. The larger molecules are precipitated first. The smaller molecules are more soluble and require higher concentrations of alcohol. By this method of partial hydrolysis, dextrans of a molecular size suitable for infusion solutions may be obtained. The molecular weight given for dextran usually represents an average of the weights in the specimen tested; for example, the usual "clinical dextran," with an average molecular weight of 75,000, may have a molecular weight distribution of between 10,000 and 300,000.

Although the dextrans have many clinical applications, this report will be limited to their use in preventing or treating thrombosis. The "clinical dextran" (average weight, 75,000) and the low molecular weight dextran (average weight, 40,000) prevent thrombus formation and propagation by (1) decreasing blood viscosity, (2) increasing blood flow, and (3) coating the vessel wall and circulating cellular elements, thus increasing the negative electric charge on, and the repelling force between, these structures.^{5, 6} Although earlier reports suggested that low-molecular-weight dextran was preferable for increasing blood flow and decreas-

ing thrombus formation and propagation, recent studies favor "clinical dextran" for these purposes.^{6, 7} These reports, together with the ready availability of "clinical dextran" and its prolonged circulation time as opposed to the relatively rapid excretion of low-molecular-weight dextran, have prompted an experimental and clinical evaluation of "clinical dextran" as an anticoagulant.

Laboratory and clinical experience

Recent experiments in our laboratory have shown that "clinical dextran" was as effective as heparin in preventing thrombosis in the major vessels of dogs which were subjected to 12 milliamperes of electric current for one hour, and was more effective than low-molecular-weight dextran.⁸ Another experiment has shown that "clinical dextran" is better than heparin or Thrombolylin in preventing recurrence of thrombosis after thrombectomy in the jugular veins of dogs.⁹

"Clinical dextran" has been administered to 15 patients with arterial or venous occlusive disorders. In five of these patients it was used as an adjunct to reconstructive arterial surgery. Thrombosis did not occur in any of these vessels postoperatively. It has been satisfactorily used to salvage an ischemic, painful foot in 3 patients. It has been used in 7 patients with deep and superficial thrombophlebitis of the lower extremity. The thrombophlebitis progressed in 2 of the 7 patients, so that dextran was discontinued and heparin therapy initiated, with prompt resolution of the thrombophlebitis. The remaining 5 patients experienced resolution of their symptoms in a manner comparable to that seen with heparin therapy.

Dextran has usually been administered as 1,000 ml of a 6% solution daily for four to six days. No patient received more than 20 ml of dextran per kg per day. There were no complications which could be attributed to the drug. The results obtained suggest that "clinical dextran" is effective in maintaining vessel patency when combined with good vascular surgery, and that it is a satisfactory agent, though probably not quite as effective as adequate heparinization, for the

treatment of acute thromboembolic disorders. However, the ease of administering dextran as a single intravenous infusion and without the necessity for regulating the dosage by clotting times may make this a more popular agent.

Thrombolysin

Thrombolysin is the most widely used thrombolytic preparation at present. It is prepared by combining human plasminogen (profibrinolysin) with purified streptokinase (a fibrinolytic activator). The plasminogen is converted to plasmin (fibrinolysin) by enzymatic action. Frequently some of the excess streptokinase remains mixed with the plasmin. The plasmin is a proteolytic enzyme capable of digesting plasma proteins, especially fibrin and fibrinogen.

Plasminogen activators may be found in urine (urokinase), saliva, tears, milk and other body fluids, and in the walls of blood vessels. These activators are found in the plasma after exercise, stress, ischemia, and pyrogenic reactions. An excess of circulating antiplasmins is present to protect against excessive fibrinolysis which could result from the release of the tissue activators into the blood.

Thrombolysin comes as a sterile, dry powder which should be reconstituted with any of the standard intravenous fluids immediately before infusion. It may be given as a continuous drip or as intermittent injections. The intermittent injections appear to be more effective because of the short time required for degradation of the plasmin.

Clinical experience with Thrombolysin in more than 120 patients has shown that the amount of thrombolysis induced is proportional to the amount of the agent infused. It has been found, however, that as long as the prothrombin concentration remains at least 40% of the control, excess fibrinolytic activity and bleeding do not occur. Thus, frequent determinations of fibrinolytic activity are not needed to determine the amount of Thrombolysin that can be safely infused, but they are needed to indicate the effectiveness of the infusion. A euglobulin lysis time of 30 minutes or less most often insures a good

therapeutic result. If laboratory facilities are available to determine the euglobulin lysis time, the determination may be used to evaluate the effectiveness of the infusion.

Surgical intervention was pursued whenever it was indicated in the 120 patients. Fibrinolytic therapy was used as an adjunct to surgical treatment of occlusion of the larger vessels and was the principal method of treatment for occlusions of the smaller vessels. Fifty thousand units dissolved in 20 ml of sterile saline were injected into arteries or veins following thromboembolotomy. Depending on the response to surgery, additional Thrombolysin was given as indicated.

When Thrombolysin was used as the principal method of treatment, a loading dose of 150,000 to 200,000 units was given intravenously or intra-arterially. If the prothrombin concentration remained above 40% of that of the control, additional doses were given at the rate of 100,000 to 250,000 units every four hours according to the weight of the patient and the response to the previous dose. The majority of patients were treated for 24 hours. The amount of Thrombolysin used ranged from 100,000 to 3,400,000 units, with most patients receiving between 600,000 and 1,500,000 units.

After the Thrombolysin therapy was discontinued, anticoagulation was maintained by the use of heparin. These patients were found to be very sensitive to heparin after the fibrinolytic therapy and usually required only half the estimated dose to maintain the desired level of anticoagulation.

Even though fibrinolytic therapy induced by Thrombolysin was found to be useful and safe in those cases of vascular occlusion not amenable to surgery and as an adjunct to vascular surgery, it was noted that the thrombolytic results were not predictable. Subsequent experimental studies have shown that in dogs, the effectiveness of Thrombolysin decreases as the age of the clot increases, so that it has virtually no effect on thromboses that have been present for 24 hours or longer.¹⁰

Febrile reactions (38-39 C) occurred in approximately 10% of the patients receiving

Thrombolytin. The fever responded dramatically when the drug was withdrawn and aspirin and an antihistaminic agent were administered. An occasional patient will have a sensitivity reaction to the streptokinase in the Thrombolytin preparation. Bleeding has not been a problem as long as the prothrombin concentrations are maintained at levels higher than 40% of the control. If bleeding does result from an excess of Thrombolytin, it can be rapidly reversed by the use of epsilon aminocaproic acid,* a fibrinolysin inhibitor.

Urokinase

Urokinase is a potent, complete activator of plasminogen found in urine. Recently it has become possible to prepare human urokinase in quantities adequate for clinical investigation. The agent is prepared according to standards defined by the Thrombolytic Agents Committee of the National Institutes of Health. Urokinase is non-antigenic and non-pyrogenic, and has virtually no thromboplastic properties. These properties suggest that it may become the best agent for inducing thrombolysis.

Because urokinase is such a promising thrombolytic agent, the case histories of seven patients who have recently been treated with it will be summarized.

Case Reports

Case 1

A 19-year-old white woman had an acute left iliofemoral thrombosis. She received 3,724,000 units of urokinase over a period of 48 hours. Progression of the thrombosis ceased and vessels became patent as evidenced by phlebograms, measurements, and regression of symptoms.

Case 2

A 72-year-old white woman with severe diffuse atherosclerotic occlusive disease presented with the onset of acute ischemia in the right lower extremity. Motor and sensory deficits of the right foot were noted. Femoral arteriograms showed no arterial filling of any of the major vessels distal to the superficial femoral artery. She received 3,724,000 units of urokinase over 48 hours. Three hours after the infusion began she experienced return of sensation and by the next morning motor function had returned. At the end of the infusion heparin therapy was begun, and the patient was discharged from the hospital with a viable foot.

Case 3

A 45-year-old white woman had ischemia of the right hand following retrograde brachial catheterization on the corresponding side. She received 1,372,000 units of urokinase over a period of six hours. Approximately three hours after the infusion was begun, the right radial pulse had returned, the pain had disappeared, and her hand became warm. From then on the pulses remained, although never as strong as they had been prior to catheterization.

Case 4

A 35-year-old woman had a left iliofemoral thrombosis. This patient had a malignant tumor of the pelvis which was thought to be at least partially occluding the iliac vein. However, it was elected to evaluate the effect of urokinase in this situation. She received 898,000 units of the drug over nine hours, with no change in the phlebograms, swelling, or symptoms.

Case 5

A 50-year-old white man was found to have pulmonary emboli in the arteries of the right upper and lower lobes, and in the artery to the left upper lobe. He received 2,883,000 units of urokinase over eight hours. During the infusion his respiratory rate lessened, his blood pressure returned toward normal, and he became less agitated. Two days later pulmonary function studies demonstrated better oxygenation and less diffusion problems. Repeat angiograms indicated improved blood flow to both right upper and lower lobes, with little change on the left.

Case 6

A 66-year-old white man had undergone thrombectomy on two previous occasions for left iliofemoral thrombosis. On the fourth day after the second operation he was noted to have undergone thrombosis again, even though he was receiving heparin. A phlebogram demonstrated an occlusion of the deep venous system, and urokinase therapy was begun, consisting of 4,409,990 units given over 11 hours. The thrombotic process was partially resolved, with opening of channels into the iliac veins and vena cava. An aortogram demonstrated a large aneurysm of the iliac artery obstructing the left iliac vein. This was thought to have contributed to his recurrent thrombosis and perhaps to have impaired the effectiveness of the urokinase.

Case 7

A 52-year-old white woman presented with obstruction of the superior vena cava and pulmonary embolism, confirmed by history, physical examination, angiograms, and pulmonary perfusion scans. She received 2,511,000 units of urokinase over eight hours; however, neither her clinical course nor the pulmonary perfusion scans were altered. It is presumed that the underlying disease (metastatic carcinoma of the breast) altered the effect of the urokinase.

Comment

It can be seen that good results were ob-

*Amicar-Lederle Laboratories.

tained in four of the seven patients treated with urokinase. The three poor results were obtained in patients with mechanical obstructions (tumor in two and an aneurysm in one) of the thrombotic vessels. Laboratory tests indicated that an active thrombolytic state occurred in all the patients.

One must remember that although urokinase appears to be very promising, it is still an investigational agent. Studies are under way to determine what type of thrombotic occlusions are best treated with it. The dosage and duration of treatment also need to be established. Although overt bleeding and falling hematocrit levels not associated with overt bleeding have been reported by others to be associated with urokinase therapy, these complications were not noted in the foregoing series of patients. The incidence of febrile reactions, sensitivity reactions, and the like has been extremely low; in fact, there has been none in our experience.

Summary

Any physician who may be called upon to treat acute thrombotic vascular occlusions should be acquainted with agents that will stop or reverse the thrombotic process. Vascular surgeons in particular must be thoroughly familiar with these agents.

The best available agents for stopping the thrombotic process are heparin and clinical or low-molecular-weight dextran. The best available agent for inducing fibrinoly-

sis is Thrombolyisin. Methods of action, modes of administration, and results obtained from these agents are presented.

Experience with urokinase, an investigational agent capable of inducing fibrinolysis, is discussed. It appears that this drug will be a potent addition to the physician's antithrombotic armamentarium. Currently I prefer heparin to inhibit thrombosis, and urokinase to induce thrombolysis. These two agents may be used simultaneously.

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Of all the causes which render the life of man short and miserable, none has greater influence than the want of proper exercise; healthy parents, wholesome food, and proper clothing will avail little, where exercise is neglected. Sufficient exercise will make up for several defects in nursing, but nothing can supply the want of it. It is absolutely necessary to the growth and the strength of children.—William Buchan: *Domestic Medicine, or a Treatise on the prevention and Cure of Diseases by Regimen and Simple Medicines*, etc. Philadelphia, Richard Folwell, 1799, p. 36.

Evaluation of a Strip Test for Cerebrospinal Fluid Protein and Sugar

J. C. MCALHANY, JR., M.D.

WINSTON-SALEM

There are times when the chemical determination of cerebrospinal fluid (CSF) protein and glucose is needed, but the quantity of fluid is limited or laboratory facilities are not readily available for immediate analysis. Such situations could be relieved by a simple, rapid paper strip test which can be shown to have semi-quantitative clinical value.

The purpose of this paper is to review past experience with paper strip tests of CSF and then to present data resulting from such a test* and evaluate its semi-quantitative significance.

History

Dye strip tests were initially performed on urine. Frazer,¹ in 1958, substantiated the use of one such test** for the detection of proteinuria. He found it difficult to match the strip with accuracy against any one step on the manufacturer's color scale (negative, trace, 1 plus, 2 plus, 3 plus, 4 plus), and it appeared more satisfactory to him to record the results as "negative," "trace," or "positive," without more precise assessment. Thus he did not recommend semi-quantitation of results apart from this rough classification. He investigated and substantiated the manufacturer's recommendations regarding immersion of the strip and reproducibility of the results.

In 1959 Jacobs² used this same test (Albustix) on CSF and correlated the readings with quantitative laboratory values. He carried out determinations on 50 specimens and noted that "after a few determinations, it was easy to determine the reading in advance from levels of 16 mgm% to as high as 325 mgm%."

Kutter,³ in 1964, used a strip test (Clinistix), which had no color chart, for the determination of glucose in CSF, and based

his semi-quantitations on the time elapsed between contact of the paper with the fluid and the appearance of a distinct blue color on the strip. He predicted glucose levels in five unknown samples with a range of variation of 0 to 10 mg/100 ml from established glucose levels. Since his method did not yield absolute values, owing to differences in the appreciation of color from one observer to another, he recommended that each observer determine a calibration curve based on reaction times. Kutter also used the strip test (Albustix) for determining CSF protein based on the semi-quantitative scale suggested by the manufacturer and found excellent correlation in five samples, with no variation from the semi-quantitative predictions.

Watson,⁴ in 1964, however, emphasized the limitations of this screening test for protein (Albustix) on CSF. Inconsistent results were obtained in 50 determinations, with discrepancies both on the high and low side of the semi-quantitated strip readings. He also demonstrated that the paper strip exhibited marked differences in sensitivity toward different proteins, being much less sensitive to gamma globulin than to albumin, and stated that "since the gamma globulin of CSF is known to be abnormally elevated in multiple sclerosis, neurosyphilis, and other neurologic conditions, this use of a strip test for CSF protein testing (which the manufacturers have never recommended) must be discouraged." Watson suggested that the inconsistent results might have been due to difficulties in matching the end of the strip, but noted that a more uncontrollable cause might have been a relative increase in the gamma globulin concentration of some samples.

Since the advent of the combination strip test for protein, glucose and pH, it was thought practical to evaluate this test against a larger number of CSF samples, with sta-

*Comblstix, Ames Company, Inc., Elkhart, Indianan.

**Albustix, Ames Company, Inc.

tistical analysis to determine if semi-quantitation of readings is possible.

It should be mentioned that CSF has been considered more suitable than urine for strip-test analysis. Kutter³ emphasized that the physical and chemical characteristics of urine such as density, pH, levels of ascorbic acid, uric acid, and glutathion may vary within large limits and may also inhibit one or another phase of the dye reactions; however, the properties of CSF are comparatively constant, offering ideal conditions for analysis. Moreover, CSF is colorless and its pH practically constant, which make conditions optimal.

Materials and Methods

The strip test used in this evaluation was the detection of protein, glucose, and pH. The protein test component is composed of a dye, tetrabromphenol blue, and a citrate buffer; and the color readings are a function of the change in color of the indicators in the presence of protein when the pH of the reaction is fixed by the citrate buffer. The glucose test portion consists of a specific glucose oxidase reaction, with oxidation of glucose to gluconic acid and hydrogen peroxide, which then reacts with chromogen (orthotolidin) to produce the changes in color. No significant quantitation is provided in the strips, but semi-quantitative values as suggested by the manufacturer are as follows:

Protein		Glucose	
mg/100 ml			
Negative	0	Negative	0
Trace	5-20	Light—small amount	
1 plus	30	($< \frac{1}{2}\%$)	
2 plus	100	Medium—may detect small	
3 plus	300	or large amount	
4 plus	>1000	Dark—large amount	
		($< \frac{1}{2}\%$)	

The reproducibility of the strip-test results in this series was tested by the simultaneous use of three to five strips in approximately 25 samples and found to be consistent throughout. The manufacturer's directions for immersion of the strip and time of reading were followed.

Protein: May be read immediately.
Glucose: Read after 10 seconds from time of immersion.

The strips used were from fresh, uncontaminated, unused supplies, properly stored according to directions.

CSF samples

The CSF samples used for analysis were unselected, being taken routinely from the clinical laboratory of North Carolina Baptist Hospital. During the period of testing the samples were collected daily after final examination by the clinical laboratory, and strip readings were taken without prior knowledge of the quantitative data obtained. Then the quantitative values of the CSF samples were obtained and charted.

The CSF samples were those arriving in a clinical laboratory without prior selection as to patient, disease process, or reasons for analysis. It was hoped thus to eliminate any bias as to suspected findings. Also all readings were taken by the author to eliminate color discrepancies between observers. All grossly bloody specimens were discarded from analysis, and the quantity of CSF had to be sufficient for complete immersion of the strip reagents..

The quantitative values were determined by Hoffman's method,⁵ using an autoanalyzer for glucose and the biuret reaction⁶ for protein determination. Normal values for this laboratory are as follows:

Protein: 15—55±SD 4.5 mg/100 ml
Glucose: 45—70±SD 5.5 mg/100 ml

Results and Interpretation

Protein

The results (Table 1) were analyzed by Fisher's analysis of variance.⁷ With $P < 0.001$, chance variation is thus eliminated.

Table 1
Protein Determinations

	No. Observations	Mean±SD mg/100 ml
Negative	32	44±20
Trace	84	52±16
1 plus	30	64±16
2 plus	63	162±131
3 plus	24	742±326

Each mean was then tested against all others by Duncan's New Multiple Range Test⁸ to

determine the levels of significance between means; however, due to the wide difference in standard deviation (SD) reflected in the 2 plus and 3 plus groups, Bartlett's maneuver* was applied to the statistical evaluation to minimize this deviation, and significance levels were then determined (Table 2).

Table 2
Significance Levels for Protein Readings

	Trace	1 Plus	2 Plus	3 Plus
Negative	.05<p<.01	p<.01	p<.01	p<.01
Trace		.05<p<.01	p<.01	p<.01
1 plus			p<.01	p<.01
2 plus				p<.01

Accepting a significance level of $P<0.01$ for these data, we see that the difference between the values of the negative, trace, and 1 plus groups are not significant; however, there is a significant difference between these three groups and the 2 plus and 3 plus groups, and also between the 2 plus and 3 plus groups.

It is noteworthy that the negative, trace, and 1 plus readings correspond to a range of normal values, while the 2 plus and 3 plus readings represent abnormal values except for 2 of 63 determinations in the 2 plus group. Since 61 of 63 determinations were in the abnormal range, with a greater range of values for a fewer number of observations, the deviation is expected to be large. It is evident that even with this wide SD, the means are still significantly different.

It should be mentioned that no 4 plus readings were obtained, although 6 of the 24 3-plus readings were greater than 1000 mg/100 ml. This fact emphasizes that the semi-quantitative scale provided with the strip test is not applicable to CSF protein, as is evident from the other values when compared to the suggested semi-quantitative scale for the corresponding colors. However, the data indicate that semi-quantitation of the strip test is possible, since significant differences between the means do occur. This semi-quantitation would entail the blind testing of known protein concentrations in a

spinal-fluid-like medium with the strips and subsequent statistical analysis.

As mentioned, the color readings cannot be semi-quantitated with the values obtained in this series owing to the wide variation of values in the statistically significant groups; however, a practical clinical application on a qualitative basis is suggested by the data as follows:

Negative	Normal protein concentration
Trace	
1 plus	
2 plus	Moderate increase in protein concentration
3 plus	Marked increase in protein concentration

There was no attempt to break down the protein constituents into albumin and globulin components, since the results reported by the clinical laboratory included total protein concentration.

Glucose

These results (Table 3) were analyzed by the method described for protein with the exception of Bartlett's maneuver, which was not used in this analysis. With the analysis of variance, $P<0.001$, chance variation was again excluded. Significant differences were also noted between all means (Table 4).

Table 3
Glucose Determinations

	No. Observations	Means±SD mg/100 ml
Negative	18	17±10
Light	18	34±11
Medium	28	53±13
Dark	100	65±15

Table 4
Significance Levels for Glucose

	Light	Medium	Dark
Negative	p<.01	p<.01	p<.01
Light		p<.01	p<.01
Medium			p<.01
Dark			

Thus we can see that semi-quantitative values may be utilized for strip-testing of CSF glucose with statistical reliability. It is not suggested, however, that the values obtained be used semi-quantitatively, as these

*Logarithm of all observations with subsequent statistical analysis.

values are also obtained from a random sampling of CSF and the true semi-quantitation must be based on the blind testing of known concentration of glucose.

It is noteworthy that these determinations the values obtained for each color reading are favorably compared to the suggested percentage of glucose concentration accompanying the strip test (Table 5).

Table 5

Reactions of Urine and CSF with Glucose Strip Test

Color Change	Manufacturer's Interpretation (Urine)	Observed Glucose Values (CSF)
None	0	Abnormally low glucose levels 17 10 mg/100 ml
Light	< 1/2 %	34 ± 11 mg/100 ml
Medium	< 1/2 % or > 1/2 %	53 ± 13 mg/100 ml
Dark	> 1/2 %	65 ± 15 mg/100 ml

Again we can suggest a practical application of the findings in Table 5 for CSF glucose levels until precise levels of semi-quantitation are established.

Negative—Abnormally low glucose level

Light—Low glucose level

Medium—Normal glucose level

Dark—Normal glucose level

Conclusions

1. The use of a strip test for the determination of CSF protein and sugar has practical clinical application.

2. Statistically significant differences ($p < 0.01$) were found between color gradients of a strip test after comparison against quantitative values in the determination of CSF protein and glucose, indicating that semi-quantitation of such a strip test is possible for use with CSF.

3. The data presented indicate that the use of a strip test for the detection of protein and glucose concentrations in CSF can be

clinically applied at present with statistical accuracy on a qualitative basis for the detection of abnormal protein elevations and abnormal glucose depressions.

Summary

The use of strip tests for the semi-quantitative determination of CSF protein and glucose is reviewed.

An analysis of a non-selected CSF population was undertaken by the use of a currently available strip test and comparison of results with quantitative laboratory values. The data were statistically evaluated to determine if semi-quantitation of such a strip test was possible.

A practical clinical use of this strip test on CSF for the detection of abnormal amounts of protein and glucose is suggested.

Acknowledgements

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In the more advanced periods of life we often acquire an inclination for food which, when children, we could not endure. Besides, many things may, by habit, agree very well with the stomach of a grown person which would be hurtful to a child; as high-seasoned, salted, and smoke-dried provisions, etc. —William Buchan: Domestic Medicine, or a Treatise on the Prevention and Cure of Diseases by Regimen and Simple Medicines, etc. Philadelphia, Richard Folwell, 1799, p. 34.

History of the Guilford County Health Department

JOHN LAYNE SCOTT

The wilderness that was to become Guilford County was first settled by Scotch-Irish, Quakers, and German immigrants who had found the land prices too high in Pennsylvania. Most of these pioneers came down the "Great Philadelphia Wagon Road," which stretched from the Schuylkill River at Philadelphia to Wachovia, and thence to Salisbury.¹

The North Carolina Legislature established Orange County in 1752 and Rowan in 1753 to provide for the administration of this rapidly growing area. Guilford County was formed in 1771 from parts of Orange and Rowan counties. The justice of the peace of the new county, in addition to many other duties, was charged with "the care of the sick and the poor," a responsibility that was borne by him and his successors for the next 110 years.² This responsibility involved little concrete action, since the farms were widely scattered and the self-reliant people knew almost as much about the primitive brand of medicine practiced in that day as did most of the doctors.

Guilford County's brief appearance on the international scene came on the afternoon of March 15, 1781, when Greene met Cornwallis in the Battle of Guilford Court House. Accounts of the battle fail to mention the justice of the peace, but credit local women with tending the wounded Continentals and Red Coats.³

In 1881, one hundred years after the battle, the county set up the office of county superintendent of public health. Dr. W. P. Beall of the village of Greensboro was the first to hold this non-paying position, while deriving his living from private practice.²

The need for environmental and epidemiologic controls had been dramatically revealed by the Civil War. In 1877 a law establishing the State Board of Health was passed largely through the efforts of Dr. Thomas Fanning Wood, who served the Confederacy as an army surgeon. During his service in various hospitals, field encamp-

ments, and prison camps, he was made acutely aware of the tremendous possibilities in the field of preventive and environmental medicine.⁴

During the war Guilford County was bisected by a new railroad running from Atlanta to Richmond. The trains carried men and materiel north and returned with carloads of Yankee prisoners and Rebel wounded. Those too badly wounded to travel farther were admitted to the two hospitals in Greensboro; others were transported to hospitals farther south. The prison camp at Salisbury became a laboratory of infectious diseases. There three thousand men died from rampaging diseases. It was just such situations as these that brought medical thinking to the point of considering the community aspects of health and disease.⁴

From 1880 to 1911 various physicians served as superintendent of health in addition to their private practice. The duties of this position were somewhat nebulous, and discharge of responsibility varied widely with the doctors who held the job.²

In 1911 the County Commissioners went before the General Assembly and requested legislation providing for a county board of health with a full-time physician serving as director. This request was granted, and on May 1, 1911, the Commissioners appropriated \$2500 for the salary of a superintendent of public health. The *Daily Record* of May 18, 1911, announced that Dr. George Floyd Ross would begin his duties in this capacity on July 1.⁵

Dr. Ross's first act in the new post was to issue a letter to all Guilford County physicians⁶ outlining three general regulations effective July 1, 1911. These procedures were basically as follows:

1. All births and deaths were to be reported on forms provided by the Board of Health.
2. All cases of smallpox, diphtheria, scarlet fever, measles, mumps, and typhoid were to be reported immediately.
3. In cases of smallpox, all members of

the patient's family and other exposed persons were to be vaccinated or show proof of a successful vaccination within five years.

One sentence of the letter was very significant: "The above rules do not apply to the incorporate limits of Greensboro and High Point."⁶

The county thus had three different sets of health regulations. This resulted in some duplication of effort, and attempts at consolidation were not completed until 1949.

The *Record* of July 1, 1911, announced jubilantly on page 1: "Guilford leads all other counties in the Southeast in the employment of a physician to devote his entire time to the health of the county."⁷

This hometown boast is very difficult to document, but Dr. Jacob Koomen, Acting Director of the North Carolina State Board of Health, says that the honor of being the first county in the United States to form a health department should probably be shared by Guilford and Granville of North Carolina and a county in Washington State.⁸

After one year in office Dr. Ross was replaced by Dr. W. M. Jones, who served for 11 years. Soon after taking office in August, 1912, Dr. Jones noted the loss of the records of previous meetings of the County Board of Health by Dr. Ross. After entering the absence of the notes in the record, the board proceeded to consider the case of a physician who had failed to report a death from diphtheria. It was decided to prosecute, and the county attorney was directed to carry out proceedings against the delinquent physician.⁹

In 1914 a law requiring the quarantine of smallpox was passed. Other advances included the hiring of a nassistant health officer to help Dr. Jones with the school health program, which had been extended to include the city school. This program consisted of physical examinations and lectures on hygiene and sanitation in addition to regular inspections.

During the influenza pandemic of 1918, the Guilford County Health Department rose to the challenge and provided leadership during this difficult period. Rigid quarantine laws were passed and enforced. For a

time all public gatherings were prohibited. The addition of a dentist on a part-time basis was a significant advance, overshadowed by the influenza control effort. The first public health nurse was added to the staff in 1920. Since adequate public funds were not available, her salary was paid by the Red Cross.

In December, 1924, Dr. R. M. Buie began 25 years of leadership as Health Officer. The progress of the department was slow but steady. A second nurse was employed in 1926, a sanitation officer in 1930, and a third nurse in 1931. A full-time dentist was employed in April, 1932, but the budget was reduced 10% because of the depression. This reduction resulted in only part-time employment of the dentist and the abolition of the office of Assistant Health Officer. Following the cut, the 1932 budget amounted to only \$15,000.¹⁰

Members of the local medical society were also feeling the effects of the depression. On August 1, 1932, several members met with the Board of Health, the County Commissioners, and the Greensboro Health Officer. The doctors claimed that people who were able to pay for medical care and immunization were getting these services free at the Health Department. An agreement was reached that called for more careful investigation of cases and the issuance of free service cards by the Welfare Department.¹¹

Consolidation

Attempts to study health problems in Guilford County were made in 1919, 1930, and 1943, but either no concrete recommendation for merger was presented or no action was taken. Finally, in 1947, at the request of county and city officials, the North Carolina State Planning Board made a survey and recommended consolidation of the three health departments. As a result the county appointed a special study committee of 54 members. In a report dated July 23, 1948, the committee recommended, and finally obtained, a legislative act (Senate Bill 167) which effected the consolidation of the departments.

Thus on July 1, 1949, the merger of the three separate health departments—Guil-

ford County, Greensboro, and High Point—was finally accomplished. The combined department was called the Guilford County Health Department. In 1949, prior to merger, the county staff consisted of a health officer, a sanitation engineer, two sanitation officers, four nurses, and a clerk. The budget for the year ending July 1, 1949, was \$39,840. After merger the combined staffs consisted of 58 persons and the department's budget for the first year was \$274,262.

On June 3, 1949, Dr. E. H. Ellinwood was appointed Health Director of the combined department. The former directors of the three separate departments were named assistant health officers. They were Dr. Loren Wallen of the High Point unit, Dr. F. K. Harder of the Greensboro unit, and Dr. R. M. Buie of the county unit.¹²

Under the continuing leadership of Dr. Ellinwood, the Guilford County Health Department has made, and is still making, significant contributions to the health of the community as well as providing an excellent laboratory for field research. Projects have included the Cornell Automotive Crash Injury Research Study, a study of infectious hepatitis under the UNC School of Public Health, and field training of public health

Nurses from UNC and A & T College of Greensboro. Guilford County was the only county in North Carolina to be chosen for the evaluation of the Salk polio vaccine and a significant study of the public health aspects of chronic disease.

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Roots which contain a crude viscid juice should be sparingly given to children. They fill the body with gross humors, and tend to produce eruptive diseases. This caution is peculiarly necessary for the poor; glad to obtain at a small price what will fill the bellies of their children, they stuff them two or three times a day with greasy potatoes, or other crude vegetables. —William Buchan: Domestic Medicine, or a Treatise on the Prevention and Cure of Diseases by Regimen and Simple Medicines, etc. Philadelphia, Richard Folwell, 1799, p. 35.

Report on Trauma

EPIDURAL HEMATOMA

Although epidural hematoma is not a common complication of head injury, it remains one of the most important traumatic neurosurgical lesions for the simple reason that the untreated case frequently terminates fatally, while the *patient who is treated early can recover completely without neurologic deficit*. The mortality rate has been reported as 40-50 per cent. In our opinion, the high mortality and morbidity are directly related to problems of diagnosis rather than surgical therapy. The treacherous nature of this potentially lethal, potentially curable lesion may be emphasized by the following diagnostic points.

1. The head injury may seem to be relatively minor. Low-velocity, blunt impacts are more often followed by epidural bleeding of surgical significance than are high-velocity or penetrating injuries.

2. Almost all epidural hematomas result from fractures, linear or depressed, which lacerate the middle meningeal vessels, the sagittal sinus, the lateral sinus, or one of the emissary veins which bridge the epidural space. However, the absence of fracture on x-ray does not, unfortunately, rule out the possibility of epidural hematoma.

3. The classical clinical course of epidural hematoma is one of initial unconsciousness (the result of brain concussion), followed by recovery of a normal or near-normal level of consciousness (the "lucid interval"), and then, deepening coma as the expanding clot produces progressive compression of the brain. However, less than half of the patients show this typical sequence. Some have no initial period of unconsciousness, owing to the absence of associated brain concussion. Others remain in various stages of unresponsiveness from the beginning because of associated brain contusion. In the former group diagnosis is complicated by the fact that the patient may remain awake and talking, with normal vital signs, right up to a point only moments before the onset

of deepening coma, pupillary dilation, decerebrate rigidity, and death. The interval between head injury and either operative intervention or death may be anywhere from a few hours to several days. The important point is that once the expanding epidural mass has produced enough compression of the brain to cause progressive lowering of the level of consciousness, pupillary dilation, hemiparesis, bradycardia, or respiratory irregularity, time is of the essence, and *the patient constitutes a real surgical emergency*.

In view of the above considerations, it would seem that every individual who has sustained a head injury of any sort should be hospitalized for 24 to 48 hours on a surgical service which is prepared, in terms of experience and equipment, to follow the patient and treat him as indicated. This ideal dictum is impractical, and the following compromise is suggested. All patients who have sustained a period of unconsciousness following head injury, and all patients with skull fractures, should be under medical observation for at least 24 to 48 hours. Those patients who were never rendered unconscious initially and who may not have had skull films—may never have consulted a physician in fact—should be hospitalized immediately in the event of progressive headache, lethargy, disorientation, or any minor sign of neurologic deficit.

For all of these patients *it becomes incumbent upon the responsible physician to establish a baseline of neurologic functions as soon as possible*, both from his own observations and from the observations of those first attending the patient. In this way, if surgical facilities are not immediately available, the physician will be able to make plans for transportation to a surgical center at the earliest sign of neurologic deterioration. It must be emphasized that to transport a patient in the face of cardiovascular or respiratory insufficiency constitutes a risk to life and neurologic function equal to that of epidural hematoma. Once the patient with intracranial hematoma has reached this stage of brain stem decomposition, his only hope of recovery lies in immediate operative intervention.

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SUGGESTIONS FOR AUTHORS

The *North Carolina Medical Journal* welcomes original contributions to its scientific pages, expecting only that they be under review solely by this *Journal* at a given time, and that they follow a few simple guidelines. The guidelines are as follows:

I. Subject Matter

Educational articles, especially those in which particular applications to the practice of medicine in North Carolina are developed, are one of the main objectives of this *Journal*.

Articles reporting original work by North Caro-

lina physicians are invited, whether the work is done in a clinic, a laboratory, or both. The editor and his consultants will evaluate the work by the usual criteria, including a proper discussion of previous work, control observations, and statistical tests where indicated.

Historical articles, especially those dealing with local history, are considered of real value and interest.

2. Manuscripts

An original and a carbon copy of the manuscript should be submitted, one for review by the editorial staff, the other by referees. The manuscript should be typed on standard-size paper, double-spaced, with wide margins (one inch on each side).

3. Bibliographic References

References to books and articles should be indicated by consecutive numerals throughout the text and then typed, double-spaced, on a separate page at the end of the manuscript. Books and articles not indicated by numerals in the paper should not be included, "unless an exhaustive review of the literature has been made on a subject of sufficient importance to warrant such a survey."¹ Such a bibliography is seldom justified.

References will be much more valuable to the reader if they are given in a proper form and contain the full information necessary to locate them easily. The *North Carolina Medical Journal* follows the form used in the journals of the American Medical Association and the *Index Medicus*, giving the author's surname and initials, title of the article, name of the periodical, volume, inclusive page numbers, and the date of publication. It is believed that this style makes it easier for the reader to judge whether the reference is likely to prove useful to him, and enables him to locate it more quickly.

4. Tables and Illustrations

Tables and legends for illustrations should be typed on separate sheets of paper. The illustrations should be glossy black-and-white prints or line drawings. It is necessary to obtain permission from the author or publisher to reproduce illustrations which have been published elsewhere.

The *North Carolina Medical Journal* pays up to \$20 on the cost of cuts for any one article. This amount usually covers the expense of reproducing from two to five illustrations, depending on the size and type of cuts required. Line drawings and graphs are usually less expensive to reproduce than photograph. Authors may publish additional illustrations by paying the extra cost.

The style followed by this *Journal* will be, in general, that outlined in the Style Book issued by the Scientific Publications Division of the American Medical Association, John H. Talbot, M.D., director.

By following the above suggestions, writers will greatly expedite the publication of papers accepted by the *North Carolina Medical Journal*.

1. Fishbein M.: Medical Writing, ed. 2, Chicago, American Medical Association, 1948.

SUMMER WITHOUT POLIO

The medical school class graduated in June has now gone onto the wards without, in almost every case, ever having seen a patient with acute poliomyelitis. It is unlikely that most of them ever will see a case. What they have heard about the disease no doubt got that detached sort of attention given to matters historic, and should they see a case they likely would miss the diagnosis. A few of the graduates may have had personal or vicarious experience with polio, as exemplified in the recent JOURNAL article by a Bowman Gray student discussing the Greensboro polio hospital. Such experiences will be with the new physicians for a few years longer, and dealing with late effects of polio will remain for even more years. But for practical purposes, polio in this country is a disease on its way to the history books.

These reflections are prompted by two things: First, the appearance recently of an account of Jonas Salk's part in the development of polio immunization, which serves as a reminder of the power struggles that go on in the health field; second, the thought that disease entities seem to have an existence of their own, being born, maturing, and sometimes undergoing retrogression and dissolution. An example is hospital gangrene, a feared disease 150 years ago and unknown today, which disappeared without identification of its cause or development of treatment. Another example is the frequency of conversion reactions among the soldiers of the 1914-18 war, with things like hysterical blindness and paralysis so common, as contrasted with the anxiety reactions of the 1939-45 war. One inevitably wonders what disease will next largely or entirely disappear from the scene. We all have many we would nominate for the honor.

* * *

THE ALL-AMERICAN ARM-PIT

While we have justifiably been accused of being a mammophilic society, not so much attention has been given to our axillary preoccupations. This is not to say that arm-pits are on view each night on TV, or that

starlets are carefully screened for the constitution of that area—rather, the fossa is dealt with in the ads by smiles, growls, clouds of spray, views of various applicators, and repetition of magic phrases promising odor-free days. The physician sees a fair number of the clean-arm-pit set after they have developed skin trouble from irritating depilatory agents or deodorants, and these unfortunates would seem forever doomed to wander outside the mainstream of U. S. society, smelling badly, hairily wrong. For them, we offer through physicians a bit of solace from a poet, a source of insights and comforts since the time of the psalmist. In this case it is, appropriately, an American poet of preaxillophilic days, Walt Whitman, who said "Divine am I inside and out, and I make holy whatever I touch or am touch'd from./The scent of these arm-pits aroma finer than prayer. . . ." (from *Song of Myself*)

* * *

THE FILTHY SPEECH MOVEMENT GETS TO MEDICINE

Possibly the separation of Berkeley and San Francisco kept this idea from originating in the United States, but there has been a suggestion from Britain that we might start using those well known Anglo-Saxon four-letter words in our medical communications. The proposer no doubt reasons that constant exhortations to be brief and precise in using language would find fulfillment in such words. Everyone knows what they mean, their meaning is restricted, and they are certainly shorter than their polite synonyms in current use. He also mentions that while the idea is good, it would never go over. Not only would patients be outraged at being asked to collect a — sample for a —, but the outrage would extend to the laboratory and nursing staff as well.

Maybe if we all stop bathing and start growing beards the movement will grow, but so long as we remain so delicate as the deodorant ads suggest we are, the longer synonyms will be with us.

The President's Page

PUBLIC LAW 89-97, TITLE XVIII

By the time this is read, "Medicare" will have been implemented. Billions of words have been written in this connection. The tonnage of paper consumed in future writings on the subject could possibly concern forest conservationists.

We will discuss here only Title XVIII of the Social Security Amendments of 1965, and briefly at that. Nearly everyone who writes about this legislation either praises it, berates it, quotes it, or interprets it, and almost always is an authority on it. We propose neither to praise it nor berate it. We may find cause to quote the law or the directives of the Department of Health, Education, and Welfare. We may cite reference material for your detailed study. We may even suggest possibilities in the law. We will not, however, suggest a pattern of conduct for any member of this Society; we do not consider that we are an authority. You have untold opportunities to read "authoritative" material. Almost everyone in any way involved in Medicare feels compelled to express an opinion on the subject.

Information and Suggestions

1. It is suggested that each physician secure and have available in his office an actual copy of this law (Social Security Amendments of 1965, P.L. (89-97). Copies can be secured from the U. S. Government Printing Office in Washington for a small charge.

2. Carefully read, study, and critically evaluate the bulletin, "A Reference Guide to Health Insurance Under Social Security—For Physicians" (OASI—876, June 1966), which has been sent to each physician.

3. Be sure that your secretaries and other office personnel have a good working knowledge of the basic features of the law. They should be instructed as to *your* policy regarding the fiscal handling of patients "insured" under Title XVIII, A and B. It might be wise to put these instructions in writing.

4. With regard to persons insured under

Medicare, you may choose to bill your patient directly, giving him an itemized statement of your charge which shall have on it your name, the patient's name, the diagnosis, the procedure or modality of service, the date of each service or provision of supplies, the place the service was provided, the charge for each service, and the amount the patient has paid. Under this method you collect payment for all your charges directly from the patient, who then uses your receipted statements to collect what he or she can from the carrier (see page 24, OASI—876).

There has been considerable discussion regarding the acceptance of a promissory note in lieu of payment for services in order to receipt a bill as having been paid. In this connection you are advised to consult your attorney, your auditor, and your tax adviser before making a decision.

5. A. You elect to take an assignment of benefits. In this instance, it is your responsibility to determine whether the \$50 deductible has been satisfied by allowable expenses based upon "reasonable charges" during the calendar year in which your charge was incurred. To receive payment by assignment, you must complete Part II of Form SSA-1490 according to the instructions on the reverse side. You may expect the carrier to pay you 80% of the reasonable charges for the service, *providing* the deductible has been satisfied. If not, the allocation will be less the deductible.

It would appear that as of July 1, 1966, deductibles will not have been accumulated by individual patients. Form SSA-1533 will be of future value in determining the "Status of the Medical Insurance Record" of an individual so covered.

B. You may elect to bill patients over 65 directly, just as you did formerly, without accepting assignments on Medicare patients. You may elect this method of direct billing for four Medicare patients, or five or six, and then accept an assignment on the next.

You may elect not to treat any patients over 65 providing you conform to the state laws and to the Principles of Medical Ethics just as a pediatrician may elect not to treat patients over a certain age. This choice is possible if you make it as an individual physician.

6. The Part B carrier for North Carolina is the Pilot Life Insurance Company of Greensboro. This is the part of P.L. 89-97, Title XVIII that the physician is chiefly involved with.

7. You may or may not receive, or have assigned, a code number as a provider of care.

8. Profiles could be developed for each individual physician, possibly by computers. Profiles, if developed, will be categorized by geographic region, specialty status, population densities, etc.

9. Computers or some other mechanism may be used to determine the "range of prevailing charges" with reference to localities and types of practice for the same or similar services.

10. A *customary charge* is the charge generally made by the individual physician—that is, his usual charge for the service rendered.

11. For a charge to be reasonable in the eyes of this law, it must be *both* the *customary charge* of the physician for the specific service in similar medical circumstances *and within the range of prevailing charges in the given locality*. Now, here is a sleeper. Prevailing charges are those that fall within the range of charges most frequently and most widely made in a locality for specified medical procedures or services. For example, if the charges for "X" service in a homogeneous county, like Uwharrie, from 49 similarly categorized physicians fall between \$17 and \$34 and the fiftieth physician charges \$60 for the same service, his charge probably would not be used in establishing the upper limit of the prevailing range.

12. *Medical Society Avenues*

A. The Insurance Industry Committee, with long experience in the health insurance field, will act as the arm of the Medical Society of the State of North Carolina in its relations with the carrier for Part B. This

committee has been expanded and charged with this function, subject to the usual authority vested in the Executive Council and the President of the Society. As it has in the past, the Medical Section of the North Carolina Insurance Claim Review Service will continue to make interpretations and recommendations regarding specific cases sent to it for review.

B. A part of the statement made by the Insurance Industry Committee, now a standing committee of the Society, to the Executive Council on April 30, 1966, is quoted for information.

The Insurance Industry Committee of the Medical Society of the State of North Carolina will be most pleased to act in the area of Public Law 89-97, Part B, and will work with the "Medicare" fiscal intermediary (carrier) in the same fair unprejudiced manner that it has functioned in regard to other previously handled health insurance matters.

Should the Executive Council designate this Committee and any subdivisions as may be necessary to work with the carrier for Part B of Public Law 89-97, the experience developed as a result of seven years of deliberations in the health insurance field, including "claim review" function, is considered to be of incalculable value with reference to the public interest and to the interest of all parties concerned in the implementation of Public Law 89-97.

Further, it would be the intent of this Committee to call upon other committees of The Medical Society for consultation where the need for their advice and counsel becomes apparent. This Committee will continue to represent the proper interests of the medical profession at all times.

This Committee agrees that it is advisable to enlarge the membership of the Committee to include (representation from) the specialties of medical practice. Other than for enlargement of the membership, this Committee feels, at this time, there should be no different or otherwise separate method of handling Public Law 89-97 than in handling any other health insurance matter. This will insure consistent and equitable perspective regarding all health insurance situations brought to consideration.

There is no reason that government confrontation should make this Committee any less staunch in its attitude with reference to the public interest, the interest of our patients, and the interests of The Medical Society of the State of North Carolina.

C. The Part B carrier for North Carolina has assumed the posture that it will handle Medicare claims in exactly the same fashion as it has handled its own policy claims in the past, wherein payments in such contracts were based upon usual, customary, or reasonable charges.

13. *You are urged* to give the carrier adequate information as to the procedure or service rendered. If the care involves unusual circumstances which would justify a charge over and above your usual charge, you do both yourself and your patient a disservice if you do not take time to give adequate information to the carrier.

14. It is expected that if your diagnosis follows standard nomenclature, the processing of the claim will be expedited. It is further expected that the coding of procedures, such as is common to the *North Carolina Relative Value Study* and similar studies, will accelerate handling and at the same time assure a reasonable charge allowance. For instance: Appendectomy is coded as 3261; consultation requiring a COMPLETE diagnostic history and examination is coded as 9030. When the service cannot be coded give even more specific information.

The coding followed in the AMA's new *Current Procedural Terminology* (CPT) can probably be used to advantage. Coding without description, may be utilized—for instance, with reference to diagnosis. This may be wise on occasions when spelling out the diagnosis would be detrimental to the well-being of the individual patient. In any case or situation where coding is used, initials to identify the code must be added. For example: 121.6 (CPT) signifying *Current Procedural Terminology*; or (SND), *Standard Nomenclature of Diseases and Operations*; or (ICD), *International Classification of Disease*; or (NCRVS), *North Carolina Relative Value Study*.

15. It is advisable not to escalate charges with the advent of P.L. 89-97. If physicians make reasonable charges—that is, usual and prevailing—it is also reasonable to expect that arbitrary ceilings will not be applied. You are aware of an expected increase in your overhead associated with the impact of minimal wage regulations, additional paper work, and the extra time taken in explaining the provisions of the law—what it pays for, and what it does not pay for. Further, you are reminded that a receipted bill is just what it says—a paid bill. Consideration of the use of relative value scales, such as the one adopted by the Medical Society of the

State of North Carolina in 1965, could be useful.

16. Although *utilization* is chiefly a consideration in Part A of Title XVIII, you are reminded to familiarize yourself with the function of utilization review. This is primarily a hospital-oriented function, but physicians make up the medical staff of a hospital and, as such, compose the utilization committee. These committees, in carrying out their assignment, may ruffle a few feathers at times, but it is better to be assayed by your peers than by men with brown brief cases.

The two Blue Cross associations—Hospital Saving and Hospital Care—are the fiscal intermediaries in Part A. They will be working with the administrators of your hospital in the areas applicable to Part A, and certain physicians not in private practice.

We in medicine did not want this law. We did not want it because we do not think it is in the best interest of the health care of the American people. However, it is a law. It behooves us, then, to utilize this law to best interest of our patients.

No man ever wetted clay and then left it, as if there would be bricks by chance and fortune.—PLUTARCH (46-120 A.D.)

* * *

Supplement

The foregoing material was prepared to meet a June 15 deadline for the July issue of the JOURNAL. On the day that it was to have been mailed, notice was received of President Johnson's called meeting on the implementation of Medicare to be held in Washington on June 15. The editor of the JOURNAL granted a few days of grace in order that a few comments on the meeting might be added.

Undoubtedly most of you know that President Johnson convened "at the White House a meeting of medical care leaders from every state in the nation . . . to help prepare for the start of the Medicare program on July 1." Two hundred physicians and hospital administrators were invited to participate in a "working session to provide an opportunity for a final review of the preparation for Medicare."

At this writing I am aware that the communications media have disseminated much

of the content of the President's welcoming address. It should be pointed out that many of the reports emphasized certain elements and phases of the presentation. Those commentaries which lifted statements out of context may have given impact and connotations which were modified by other material content. The President departed on numerous occasions from his prepared text. He appears to be totally and individually involved in his desire for the success of this program. It would appear that he will use his weight and power to make the implementation of "medical care" (his words) successful. He was tanned and appeared vigorous at the time of this presentation.

The communications media immediately picked up the implication that if Medicare fails or bogs down, the responsibility for problems developing therein will be thrown directly upon the health professions—physicians and hospitals, specifically.

On an "I was there, Charley" basis, no cause to disagree with this premise has been found. On the same basis, it was noted that the President commented that the East Room, where he addressed the assemblage, was the room where Abigail Adams, wife of President John Quincy Adams, once did her laundry and hung it out to dry. Whether

President Johnson had a motive in making this reference is left to individual judgment.

As this is being written, the American Medical Association has scheduled a full-day seminar on Medicare in Chicago on June 25. Undoubtedly, many helpful suggestions will come from this meeting.

Whether or not a diagnosis must be included on a bill given to a patient, when using the direct billing method, has not been fully clarified as yet.

At this point I would like to inject a personal comment. There are many issues presently confronting our country, with and without reference to the practice of medicine, on which your President holds personal views. His views may be right or they may be wrong. However, when he speaks or writes, wearing the hat of the President of this Society, he is forced to subjugate his own views. There is an operational lag in our policy mechanism that forces this or any Society president often to operate in limbo, to some extent—to straddle and vacillate—when those who know him are aware that he would prefer to be more forthright.

It is for that reason that this communication is concluded by the question, *Quo vadis?*

FRANK W. JONES, M.D.

. . . The Chinese respect for old persons was a natural outgrowth of their conception of the universe and man's place in it—a universe in which each thing and event was shaped from within by unchanging law of its own nature. The intent of Chinese culture was not simply to make men clever or comfortable but to enable men to live in harmony with the laws of nature and with each other. Permeating every aspect of Chinese life was the conviction that there is a good and a bad way to deal with each thing, a way which either helps or hinders that thing in its efforts to fulfill its natural inclinations and potential.—From an interview with Walter H. Judd, on Chinese Attitudes Toward the Elderly, *Geriatrics* 21: 110 (June) 1966.

Bulletin Board

COMING MEETINGS

New Hanover County Medical Society Symposium—Blockade Runner Hotel, Wrightsville Beach, August 12-13.

North and South Carolina Societies of Ophthalmology and Otolaryngology, Joint Meeting—Sheraton Motor Inn, Winston-Salem, September 11-13.

North Carolina State Rural Health Conference—Sir Walter Hotel, Raleigh, September 13.

North Carolina Association for Retarded Children—Jacksonville, September 16-17.

Charlotte Postgraduate Seminar—Presbyterian Hospital, Charlotte, September 21-22.

Forsyth County Heart Symposium—Winston-Salem, September 30.

University of North Carolina School of Medicine, Conference for the Non-Psychiatrist Physician on "Grief and Depression: Their Crisis Management"—Chapel Hill, October 6-8.

The Herman Cone Lecture—Greensboro Public Library, Greensboro, October 20.

North Carolina Academy of General Practice, 1966 Scientific Assembly—Hotel Jack Tar, Durham, October 27-29.

North Carolina Society for Crippled Children and Adults, Annual Convention—Mid Pines Hotel, Southern Pines, October 28-29.

Society of Nuclear Medicine, Southeastern Chapter—Jack Tar Hotel, Durham, November 3-5.

North Carolina Pediatric Society, Annual Meeting—Mid Pines Club and Golfotel, Southern Pines, November 4-5.

NEW MEMBERS OF THE STATE SOCIETY

Drs. Ralph W. Goering, ObG, 3304 Buena Vista Rd., Winston-Salem; Joe Brannon Godfrey, GP, 115 Woodland Ave., Forest City; Herbert Lee Pope, Quarters "U", U. S. Naval Hosp., Camp Lejeune; Arthur Cecil Chandler, Oph, 3519 Courtland Dr., Durham; John Payne Jimenez, R, 1911-C House Ave., Apt. 55, Durham; Irwin Stanley Johnsrude, R, 3324 Rolling Hill Rd., Durham; Joseph Allison Cannon Wadsworth, Oph, Duke Med. Ctr., Durham; Charles Edward Rackley, I, Duke Univ. Med. Ctr., Durham; Harry Stephen McGaughney, Jr., ObG, UNC Sch. of Med., Chapel Hill; Robert Andrew Goyer, UNC Sch. of Med., Chapel Hill;

Also Drs. Frederick Gilbert Dalldorf, Path, 11 Woodhaven Rd., Chapel Hill; Sylvanus William Nye, Path, Morgan Creek Rd., Chapel Hill; Joe Mendels, P, 729 Tinkerbell Rd., Chapel Hill; James Wellington Dixon, S, 606 S. Benbow Rd., Greensboro; George Harrison Evans, GP, 1301 S. Benbow Rd., Greensboro; Alfred Marx Hicks, I, 106 Westbrook, Dr., Butner; John Livingston Hazelhurst, 2626-A Elderado Dr., Amarillo AFB, Texas; Joseph Thomas Marshall, Pul, WNC Sanatorium, Black Mountain; Ben Wayne Feather, P, Hillsborough; Mario Cesare Battigelli, Ind, 1307 Wildwood Dr., Chapel Hill; John H. Cox, D, 1900 S. Hawthorne Rd., Winston-Salem.

NEWS NOTES FROM THE UNIVERSITY OF NORTH CAROLINA SCHOOL OF MEDICINE

The official go-ahead has been given for construction of a \$10.6 million addition to N. C. Memorial Hospital in Chapel Hill.

The addition, an ambulatory patient care facility, is the first stage of a long-range, three-stage expansion of the hospital.

It will provide services for a spiraling outpatient load expected to increase from 100,000 patient visits a year now to 160,000 visits by 1970. It was designed also for the teaching needs of the UNC School of Medicine when the entering class is increased from 70 to 100 students.

Construction began May 9. Completion will require about three years.

Costs are being financed by \$2.5 million in state funds supplemented by federal grants and private donations.

The outpatient service areas will be known as the J. Spencer Love Clinics in honor of the founder of Burlington Industries and, at the time of his death, president and chairman of the textile firm. Burlington Industries gave \$650,000 to help finance the first stage of the hospital expansion. It was the largest gift ever received by the University from a business firm.

The construction project also includes a surgical wing on the north side of the hospital.

* * *

Funds for a five-story "bed tower" at N. C. Memorial Hospital will be proposed to the 1967 General Assembly to permit the training of more medical and nursing students and to accommodate growing demands for patient care and research.

If approved, the tower, referred to as phase two, would be built atop an ambulatory patient care facility now in the initial stages of construction. It would add about 200 more beds for patients.

The need for the additional beds is supported by the hospital's bed census for the past year, ranging up to 95 per cent on numerous occasions. Hospital authorities consider 85 per cent occupancy as a desirable level so that some beds always will be immediately available.

* * *

A drug for use initially in emergencies to control severe bleeding in hemophiliacs has been developed in the research laboratories at the UNC School of Medicine.

It was marketed in a limited supply recently for the first time by a West Coast pharmaceutical firm.

The drug is a concentrate of antihemophilic factor (AHF), a substance essential for blood clotting but missing in hemophiliacs.

The new fraction was developed by a four-man UNC research team composed of Dr. Kenneth M. Brinkhous, Dr. Harold R. Roberts, Dr. Robert H. Wagner, and Dr. William P. Webster, working in the Department of Pathology. Collaborating was Dr. G. Mur-

ray Thelin of Hyland Research Laboratories in Los Angeles, California.

The success of the new drug in stopping and preventing bleeding in hemophiliacs was demonstrated at North Carolina Memorial Hospital with 10 patients who lacked AHF in their blood.

* * *

Dr. Philip Manire became chairman of the Department of Bacteriology and Immunology at the University of North Carolina School of Medicine on July 1, 1966.

He will fill a vacancy to be created by the retirement of Dr. D. A. MacPherson, who joined the medical faculty here in 1923 and established the Department of Bacteriology six years later.

Dr. Manire came to the Medical School in 1950 as an assistant professor of bacteriology and immunology. He became a full professor in 1959.

He has served during the past year as Assistant Vice Chancellor for Health Affairs. No successor has been named yet to this administrative position.

Dr. Manire is a native of Roanoke, Texas and was a teaching assistant at North Texas University in Denton, where he earned his bachelor's and master's degrees. He was honored this spring by his alma mater with a Distinguished Alumnus Award.

He has been a Research Fellow at the University of California and a Fulbright Research Scholar at Statnes Seruminstitut in Copenhagen, Denmark.

Three years ago he was named an Alan Gregg Travel Fellow in Medical Education and went to the Institute for Virus Research at Kyoto University in Japan as a visiting professor.

* * *

A number of UNC medical faculty members have been promoted to new positions, according to an announcement by Chancellor J. Carlyle Sitterson.

Named as professors were Eszter B. Kokas and Dorothea C. Leighton.

New associate professors announced include M. K. Berkut, Jan Hermans, Hubert C. Patterson and Donald D. Weir.

Named as assistant professors were Hillel J. Gitelman, James R. Pick and Roger F. Spencer.

* * *

The appointment of Dr. James H. Scatliff, who will serve as professor and chairman of the department of radiology in the UNC School of Medicine, has been announced by Chancellor J. Carlyle Sitterson.

Now an associate professor at Yale University, Dr. Scatliff, received his B.S. and M.D. from Northwestern University. He has written several articles for professional journals and is a native of Chicago. He will replace Dr. Ernest Wood in Chapel Hill.

Other new appointments at the Medical School are as follows:

Dr. Karl H. F. Blau, University of London, assistant professor; Dr. William F. Eastman, University of Pennsylvania, assistant professor; Dr. Martin R. Krigman, Yale University, assistant professor.

* * *

Dr. Joseph S. Pagano of the School of Medicine has been selected to receive a grant of \$10,000 a year for the next five years from the Sinsheimer Fund of New York City.

He is assistant professor of medicine, specializing in infectious diseases, and assistant professor of bacteriology specializing in virology.

The Sinsheimer Fund, supported under the will of Alexandrine Sinsheimer, finances scientific research relating to the prevention or cure of human disease.

* * *

Tiny, finger-like projections on the lining of the small intestine are going to be investigated by a research team at the UNC School of Medicine.

The movements of these intestinal villi are suspected of partial blame for weight loss in patients with certain diseases or surgery of the stomach and small intestine.

The National Institute of Arthritis and Metabolic Diseases has approved a grant of \$132,869 to study the villi. The microscopic projections, for reasons that remain a mystery, have pumping movements resembling pistons in a car engine.

Dr. John T. Sessions, Jr., a specialist in gastroenterology, is the project director. He will be assisted by Dr. Oscar L. Sapp, Dr. Eszter Kokas and Dr. Michael Temko.

* * *

Many of the nation's leading experts on drug metabolism met recently at the New York University Medical Center for a workshop.

Among the faculty members were Dr. Thomas C. Butler, professor of pharmacology and director of the Center for Research in Pharmacology and Toxicology, and Dr. William J. Waddell, associate professor of pharmacology, both at the U.N.C. School of Medicine.

The five-day Drug Metabolism Workshop was or-



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NANTAHALA VILLAGE

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BRYSON CITY, NORTH CAROLINA

ganized by the National Academy of Sciences-National Research Council and the Pharmaceutical Manufacturers Association Foundation.

* * *

Problems and techniques of rescuing people in distress were discussed at a two-day North Carolina Rescue Institute.

Members of rescue squads throughout the state were invited to attend the institute on June 11-12.

The institute was offered jointly by the N. C. Association of Rescue Squads, the Western North Carolina Association of Rescue Squads, the N. C. Insurance Department and the UNC School of Medicine.

John Eric Schweistris, III of Greensboro, a rising third-year medical student at UNC, has been awarded a Grace A. Goldsmith 1966 Goldberger Student Fellowship for Research in Clinical Nutrition.

The selection was announced by the Council on Foods and Nutrition of the American Medical Association.

Schweistris will leave in mid-June to spend the summer at the University del Valle in Cali, Colombia, South America.

NEWS NOTES FROM THE DUKE UNIVERSITY MEDICAL CENTER

When Hippocrates wrote the famous oath which has been the ethical guide of the medical profession for more than 2000 years he did it while sitting under a plane tree in Cos, Greece.

On June 5, a gavel made from a plane tree in Cos was presented to the Duke University School of Medicine after 66 students swore to uphold a modernized version of the Hippocratic Oath at a ceremony in Duke University Chapel.

The gavel was a gift from Dr. Thomas Doxiades, chairman of the board of directors of Evangelismos Medical Center, Athens, Greece, and personal physician to Greece's Queen Mother Frederick. Dr. Doxiades made the presentation to Dr. W. G. Anylan, dean of the medical school.

The oath-taking ceremony was a prelude to graduation exercises June 6. Although only 66 students recited the oath, which defines the doctor-patient relationship as well as the doctor's ethic for a career in medicine, 81 students in all graduated with doctor of medicine degrees, 15 of them in absentia.

* * *

The development of a drug found to be successful in the treatment of gout was described by Dr. R. Wayne Rundles of Duke University Medical Center at an international symposium on the disease held in London last month.

The drug, allopurinol, was first used successfully for relief of the painful symptoms of gout on patients at Duke by Dr. Rundles, a professor of medicine.

Dr. Rundles, who also is director of the hematology and chemotherapy service, directed research on the drug over a period of three-and-a-half years.

Though not yet released here by the Federal Food and Drug Administration, allopurinol has been made available for general prescription use in Great Britain.

Fourteen Duke University medical school students and one faculty member were initiated into membership recently by Alpha Omega Alpha honorary medical society at ceremonies at Hope Valley Country Club.

In being accepted for membership in the society, all were accorded the highest scholastic honor that can be given medical students or medical school faculty members.

Dr. Robert J. Reeves, professor and former chairman of the department of X-ray, was the only faculty member elected this year.

* * *

Emerging patterns and practices in the hospital and health field were discussed and evaluated at a national conference held at Duke University May 20-21.

The 1966 National Forum on Hospital and Health Affairs, financed by the Duke Endowment, is the second of its kind. The first was held last year.

This year's topic was "The Hospital Patient Outside the Hospital." It examined the various services hospitals are increasingly being asked to provide. Discussion included the services provided by hospital-operated nursing homes, home care programs, ambulatory care programs, and hospital-operated doctors' offices.

* * *

The United States Commissioner on Aging, William D. Bechill, was one of several experts who participated in a symposium on "The Physician's Role in the Care of the Aging" May 26-27 at Duke University Medical Center.

Others included Dr. Amos N. Johnson of Garland, president of the American Academy of General Practice; Dr. Felix Post of London, England, internationally known psychiatrist in treatment of the aged; and Dr. Ethel Shanas, Department of Sociology and Anthropology, University of Illinois.

The two-day symposium was sponsored by the Duke Center for the Study of Aging and Human Development.

* * *

Dr. Charles Tanford of Duke University Medical Center will serve as the Arthur and Ruth Sloan Visiting Professor of Chemistry at Harvard University next fall.

Dr. Tanford is a professor of physical biochemistry.

The Sloan Visiting Professorship or Lectureship provides each year for one or two teaching visits to Harvard by distinguished chemists. In turn, this enables one or two chemists on the Harvard faculty to devote a term or a full academic year wholly to research.

During the fall term, Dr. Tanford will teach "Topics in Physical Bio-chemistry," while Prof. Paul Doty of Harvard is engaged in full-time research.

* * *

The first experimental findings implicating viruses as a cause of cancer of the liver were reported by Dr. Joseph W. Beard, a Duke University researcher, to a meeting of the American Association for Cancer Research held in Denver, Colo., recently. Dr. Beard reported on results of a series of experiments in which chickens were inoculated with a strain of virus

called MC-29. About half of the animals examined, he said, developed liver tumors.

"So far as I know," he said in an interview prior to his speech, "no one has ever seen a virus-induced tumor of the liver."

Dr. Beard is director of the virus-cancer research laboratories and professor of surgery and virology at Duke. Associated with him in the current study was Dr. Zahary Mladenov of Sofia, Bulgaria, formerly with the Duke laboratories; Dr. Ursula Heine; and Mrs. Dorothy Beard.

* * *

Dr. Lenox D. Baker, chairman of the department of orthopedic surgery at Duke University Medical Center, has received two new appointments.

The first is as a member of the board of trustees of the Journal of Bone and Joint Surgery, a six-year appointment. The second post is that of chairman of a policy and personnel committee of the division of Vocational Rehabilitation of the State Department of Education.

* * *

Physicians, nurses, and health personnel from North Carolina and surrounding districts attended a three-day symposium on poisoning—accidental and deliberate—at Duke University June 11-13.

The symposium was conducted by the Duke University Poison Control Center. Its director, Dr. Jay M. Arena, a professor of pediatrics, was one of the speakers.

A high light of the symposium was a round table discussion, open to the public on poisoning in the home.

"Poor supervision in the home is the reason so many children become poison victims," Dr. Arena pointed out, adding that "downright carelessness is responsible for most of these poisonings." More than 500,000 children are poisoned annually, and some 500 of them die.

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Dr. Rubin Bressler, assistant professor of medicine at Duke University Medical Center, has been elected to membership in the American Society of Biological Chemists.

Dr. Bressler also was named a councilor in the American Federation for Clinical Research, the largest clinical research organization of physicians in the world.

NEWS NOTES FROM THE BOWMAN GRAY SCHOOL OF MEDICINE OF WAKE FOREST COLLEGE

Dr. Thomas B. Clarkson, Jr., professor and director of the Department of Laboratory Animal Medicine, and Dr. Hugh B. Lofland Jr., associate professor of biochemistry, were among 20 Americans who participated in an international symposium on "Recent Advances in Atherosclerosis" which began May 30 in Athens, Greece.

Dr. Clarkson spoke on "Pathologic Characteristics of Atherosclerosis in New World Monkeys." Dr. Lofland presented a paper on "Recent Advances in Arterial Metabolism: The Whole Artery" and chaired a session on "Metabolism of the Artery."

Medical scientists from 22 countries participated in the symposium, sponsored by the European Society for the Study of Atherosclerosis.

* * *

Dr. Millie P. Hancock, a fellow in hematology at the Bowman Gray School of Medicine for the past year, has been appointed to the medical school faculty as instructor in pediatrics.

A magna cum laude graduate of the University of North Carolina at Greensboro, she holds the M.D. degree from Johns Hopkins University School of Medicine. She took internship and pediatric residency training at Johns Hopkins Hospital. She is the recipient of a Senior Clinical Training Fellowship from the U. S. Public Health Service.

* * *

Dr. C. Douglas Maynard, resident in radiology, has been named a James Picker Foundation Scholar in Radiological Research. The scholarship was awarded through the National Academy of Sciences-National Research Council. It provides \$6,000 for the first year and is renewable each year for a three-year period.

The James Picker Foundation sponsors the program of grants for scholars in radiological research to help newly trained scientific personnel establish themselves in academic medicine.

* * *

Dr. Richard B. Patterson, assistant professor of pediatrics, is spending the summer at the Hospital for Sick Children in London, England, where he is engaged in hematology studies with Dr. R. M. Hardisty, a noted British pediatric hematologist.

His trip is supported by a Markle Scholarship in Medical Science. He was awarded the prestigious scholarship in 1962 by the John and Mary R. Markle Foundation. It provides \$30,000 over a five-year period.

Dr. John W. C. Fox, assistant professor of anesthesiology, participated in the 16th French National Congress of Anesthesia and Resuscitation and the First International Congress of French-Speaking Anesthetists and Resuscitation Specialists June 3-6 in Paris, France.

He presented a paper on "Neuroleptanalgesia in the United States," describing a new type of intravenous anesthetic technique that was developed in Europe. The paper was dedicated to the memory of Dr. D. LeRoy Crandell, who died May 10. Dr. Crandell, who was professor and director of the Section on Anesthesiology, was co-author of the paper.

* * *

The George W. Paschal History of Medicine Room in the library of the Bowman Gray School of Medicine was dedicated June 4. Named in honor of a prominent Raleigh surgeon, who is the immediate past president of the North Carolina State Medical Society, the room was dedicated to the faculty of the former two-year Wake Forest College School of Medicine, the forerunner of the Bowman Gray School of Medicine.

Dr. Paschal, a 1929 graduate who has made major contributions to the medical school as an alumnus, began efforts in 1959 for the establishment of a history of medicine room.

The room contains rare volumes of medical literature, books on various aspects of medical history, instruments used in the early practice of medicine and classic medical illustrations.

Dr. Quentin N. Myrvik, professor and chairman of the Department of Microbiology, has been appointed to the Bacteriology and Mycology Study Section of the National Institutes of Health, Division of Research Grants. His four-year appointment became effective July 1.

* * *

Dr. Robert W. Cowgill, associate professor of biochemistry, was recently elected president of the Wake Forest College Chapter of the Society of the Sigma Xi. Dr. Stephen H. Richardson, assistant professor of microbiology, was elected secretary. The Wake Forest College Chapter was established last year. Its forerunner, the Sigma Xi Club of the Bowman Gray School of Medicine, was organized in 1956.

* * *

The graduating class of the Bowman Gray School of Medicine dedicated its yearbook, "The Gray Matter," to Dr. James F. Toole, professor and chairman of the Department of Neurology. In making the dedication, the students referred to Dr. Toole as "the epitome of academician, physician, teacher and friend."

* * *

Two members of the Bowman Gray faculty participated in the annual meeting of the American Society for Microbiology in Los Angeles, Calif. Dr. Samuel H. Love, assistant professor of microbiology, presented a paper on "Conversion of Methylated Purines to Inosine by Escherichia Coli: Derepression of Adenosine Deaminase." Dr. Stephen H. Richardson, assistant

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professor of microbiology, presented a paper on "Inhibition of Ion-Translocase Enzymes from Rabbit Intestine by Culture Filtrates of *Vibrio Cholerae*."

* * *

Dr. Frank C. Greiss Jr., assistant professor of obstetrics and gynecology, presented two papers at the annual meeting of the American College of Obstetricians and Gynecologists May 2-5 in Chicago, Ill. He spoke on "Physiologic Evaluation of Blood Loss" and "Role of Combined Therapy in Cancer of the Cervix." He also presented a paper on "Management of the Menopause: Now and in the Future" at a meeting of the Southern Gynecologic and Obstetric Society May 12-14 in Sea Island, Ga.

* * *

Dr. Richard C. Proctor, professor and chairman of the Department of Psychiatry, spoke on "Use of Drugs in the Office" at May 26 seminar in psychiatry at Central State Hospital, Nashville, Tenn.

* * *

Dr. Charles L. Spurr, professor of medicine, presented a paper on "Comparative Evaluation of Cyclophosphamide and Vinca Alkaloids in the Treatment of Lymphomas" at the 57th annual meeting of the American Association for Cancer Research May 26-28 in Denver, Colo.

Dr. Clark E. Vincent, professor of sociology and director of the Behavioral Sciences Center, was the principal speaker for the University of Connecticut's

Workshop on Marriage Counseling May 6-7 in Storrs, Conn. He lectured on "Unmarried Mothers," presented a seminar on "Theory and Techniques of Marriage Counseling," and delivered a banquet address on "Marital Health and Communication."

* * *

Wilbur S. Avant Jr. of Whiteville and Wilson K. Wallace of Charlotte, both rising seniors at the Bowman Gray School of Medicine, are serving clinical clerkships this summer at the University of London (England) Hospital.

1966 State Rural Health Conference

A one-day statewide Rural Health Conference scheduled for Thursday, September 15, 1966, at the Sir Walter Hotel in Raleigh, is announced by Edward L. Boyette, M.D., chairman of the Medical Society of the State of N. C. Committee on Community Health (Rural and Urban).

Interested citizens from farm, civic, community and allied health groups are particularly urged to make plans to attend the Conference which is open to the public.

Some of the factors which can increase the risk of heart attack can be controlled. Some persons who reduce these risk factors will live longer. Some who don't . . . won't, says the North Carolina Heart Association.



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AMERICAN COLLEGE OF PHYSICIANS

North Carolina physicians were among those recently honored at the 47th Annual Session of the American College of Physicians (ACP). They were inducted into Fellowship in the 13,000-member medical specialty society which represents specialists in internal medicine and related fields.

Among the Fellows inducted were Dr. John K. Spitznagel, Chapel Hill; Dr. Charles D. Williams, Jr., Charlotte; Drs. Suydam Osterhout, J. Graham Smith, Jr., both of Durham; Dr. Edwin W. Monroe, Greenville; Dr. Kenneth E. Cosgrove, Hendersonville; Dr. Thomas E. Fitz, Hickory; Dr. Odell C. Kimbrell, Raleigh; Dr. James Tidler, Wilmington; Dr. I. Gordon Early, Winston-Salem; and Dr. Benjamin F. Huntley, also of Winston-Salem.

NORTH CAROLINA HEART ASSOCIATION

The American Heart Association has announced nine grants-in-aid totaling \$90,090 to scientists at North Carolina's three medical centers. The new heart research grants were made public by Hargrove Bowles, Jr., of Greensboro, chairman of the North Carolina Heart Association's board of directors.

The grants, part of the national heart group's \$10-million national research program for 1966-67, bring the North Carolina heart research tally to 2,747,950 Heart Fund Dollars since 1949.

Bowles also announced that the board of directors has approved a heart research budget totaling \$110,000 for the year 1966-67 for the state heart disease control agency. The American and North Carolina Heart Associations allocate more than \$275,000 each year for heart research at the state's three medical centers.

SOUTHERN MEDICAL ASSOCIATION

Benjamin L. Allen, Jr., M.D., a graduate of the Duke University School of Medicine, has been awarded a Residency Training Grant for 1966-67 by the Southern Medical Association.

The Residency Training Grant Fund was established at the 1962 meeting of the Association, to help meet the increasing need of financial assistance for physicians seeking additional education in the form of residency training and fellowships. A grant from this fund will help a physician to complete a chosen number of years of training without adding to his previous indebtedness and still receive an income which, while not necessarily commensurate with his education, will allow him a comfortable existence during this period.

The maximum grant available to each recipient is \$2,400, payable at the rate of \$200 per month for 12 months.

Official application forms for the 196-68 grants may be secured from the Executive Director, Southern Medical Association, 2601 Highland Avenue, Birmingham, Alabama 3205.

North Carolinians Invited to White House Conference on Medicare

Three North Carolina physicians were among 200 physicians and hospital administrators from across the nation asked to participate in a meeting called by President Johnson at the White House on June 15 to discuss implementation of the Medicare program July 1.

They are Frank W. Jones, M.D. of Newton, President of the Medical Society of the State of North Carolina; Amos N. Johnson, M.D. of Garland, President of the American Academy of General Practice and a consultant to the American Medical Association Advisory Committee on Medicare; and John R. Kernodle, M.D., of Burlington, a member of the Committee on Aging of the AMA.

Dr. Jones stated that "The Medical Society of the State of North Carolina is cognizant of the law and does not intend to do otherwise than comply with the law."

President Johnson addressed the meeting, which was called to provide an opportunity for a final review of the preparations for Medicare. The meeting included panel discussions on problems which may arise in certain communities where there are high proportions of aged persons.

U. S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Initial allotments, totaling \$12,716,583.15 for fiscal year 1967 under the Health Professions Student Loan Program have been made to 196 schools of medicine, dentistry, osteopathy, optometry, pharmacy, and podiatry, it was announced recently by Surgeon General William H. Stewart.

Among the institutions which have been allotted funds are North Carolina's three medical schools—Duke University, \$74,107.49; the University of North Carolina, \$65,469.20; the Bowman Gray School of Medicine of Wake Forest College, \$49,101.89.

The funds, available through the Public Health Service will be used for loans to full-time students studying to be physicians, dentists, osteopaths, optometrists, pharmacists, or podiatrists. Students in need may borrow up to \$2,500 for an academic year.

NATIONAL INSTITUTES OF HEALTH

The cooperation of physicians is requested by the National Cancer Institute in studies being conducted at the Clinical Center, National Institutes of Health, Bethesda, Md.

Physicians interested in having their patients considered for these studies should use the appropriate address from those listed with the diseases under investigation.

Hodgkin's disease and lymphosarcoma, particularly patients who have had minimal prior treatment or none. Address Paul P. Carbone, M.D., Clinical Center, National Institutes of Health, Building 10—Room 12-N-228.

Hyper- or hypoparathyroidism. Of interest are patients with kidney stones and or bone demineralization in association with high serum calcium and or low serum phosphate; also patients with hypoparathyroidism (congenital or following thyroid surgery) having low blood calcium and high serum phosphorus. Address Gerald D. Aurbach, M.D., Clinical Center, Room 9-D-14, National Institutes of Health, Bethesda, Md. 20014.

Wiskott-Aldrich syndrome. Infants or small children with chronic eczema, thrombocytopenia, hemorrhagic diathesis and susceptibility to infection. Address Thomas A. Waldman, M.D., Clinical Center, Room 4-N-110, National Institutes of Health, Bethesda, Md. 20014.

PUBLIC HEALTH SERVICE

Scholarship funds totaling \$3,307,800 have been made available for the first time to 227 schools of medicine, dentistry, optometry, osteopathy, podiatry, and pharmacy under the new Health Professions Scholarship Program of the Public Health Service. Surgeon General William H. Stewart announced recently.

The funds, granted for fiscal year 1967, were made available as a result of the Health Professions Educational Assistance Amendments of 1965. Increased enrollment of students in health professions schools is the basic objective.

The Month in Washington

Administration officials say that the doctor-patient relationship should not be impaired under medicare.

Dr. Philip R. Lee, assistant secretary of health, education and welfare for health and scientific affairs, said in an interview that federal officials, in drafting medicare regulations, had been doing their utmost to insure that the traditional doctor-patient relationship is preserved.

"The guidelines for the medicare program were developed with the close cooperation of so many physicians and other people in the health care field that this will provide the best assurance for the physicians, for the government, for Congress and for the public that the implementation of medicare will not alter the fundamental and vital personal relationship between the doctor and the patient," Lee said.

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Lee termed the cooperation of physicians and hospital officials in developing medicare guidelines as "extraordinary." He said he personally expects the doctor-patient relationship to improve under medicare because removal to a large extent of the financing problem will give a physician more leeway in ordering laboratory tests and sending a patient to a hospital.

President Johnson invited about 200 physicians and hospital administrators to a White House meeting on June 15 "to examine problems that may arise and to discuss cooperative arrangements so that the (medicare) program will get off to a good start."

Social Security headquarters at Baltimore set up an around-the-clock medicare information service to help its district offices in responding to queries from beneficiaries, physicians, hospital administrators and others.

* * *

The Defense Department has slashed by almost one-third—from 2,496 to 1,713—its special draft call for physicians to be delivered to the armed forces this summer.

Under the revised doctor draft call, the Army will take 958, the Navy 405 and the Air Force 350.

The Pentagon said casualties in Southeast Asia had been fewer than expected and the number of volunteer physicians had exceeded estimates. In reducing the call by 783, the Defense Department pointed out it had originally issued its request to Selective Service last February. At that time it used best estimates available on the number of additional physicians who would be needed for the buildup of the armed forces in connection with the Viet Nam war.

* * *

The federal government will conduct a nationwide survey to determine factors that lead people, particularly older persons, to fall for fakes and swindles in the health field.

Seven agencies of the government are joining in the study which was recommended by the Senate Special Committee on Aging Subcommittee on Frauds and Misrepresentations Affecting the Elderly. The study will

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include various groups beginning with teenagers, but it will focus on the elderly.

At hearings of the subcommittee, it was estimated that a billion dollars is wasted each year on misrepresented, unnecessary or worthless health products and services with a large share of such spending by older persons, especially those suffering from chronic and incurable diseases.

The Food and Drug Administration is coordinating the study. Joining with FDA in the survey project are the Administration on Aging; National Institute of Child Health and Human Development; National Institute of Mental Health; and Vocational Rehabilitation Administration—all within the Department of Health, Education, and Welfare; the Agricultural Research Service of the U. S. Department of Agriculture, and the Veterans Administration. A number of voluntary health agencies, the American Medical Association, and the National Better Business Bureau helped in planning the study.

The study will seek to determine the influence of such factors as family and educational background, folk medicine customs, and health experiences on consumer attitudes toward health products, services, and information. It will examine the extent to which such factors make some individuals prone to accept false and misleading promotions for health products and services, or resistant to sound medical and health information. Armed with such knowledge, the agen-

cies hope to be able to devise more effective educational and other programs to protect the public against health frauds and quackery.

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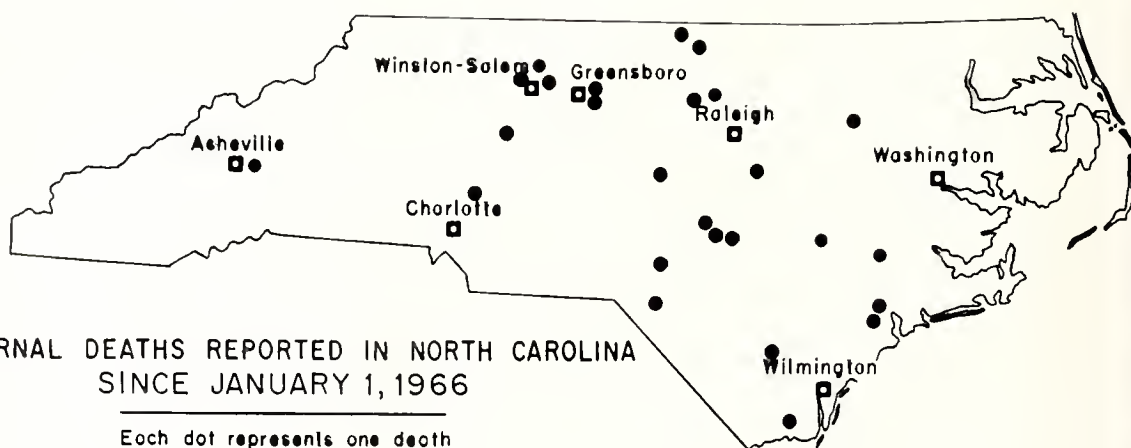
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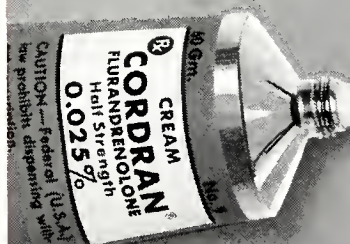
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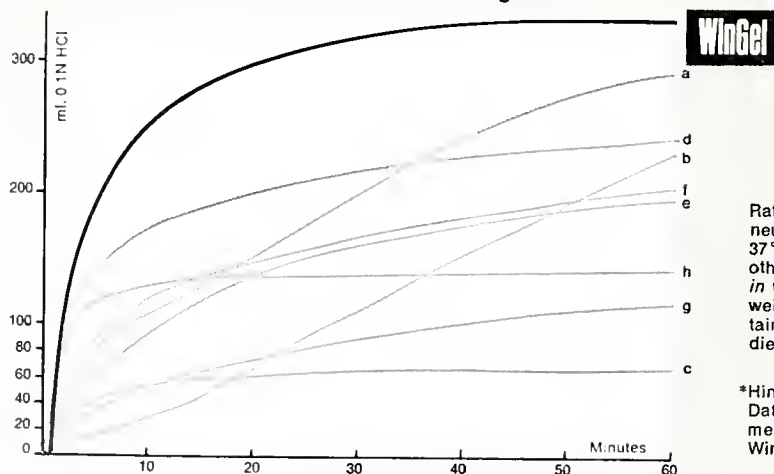
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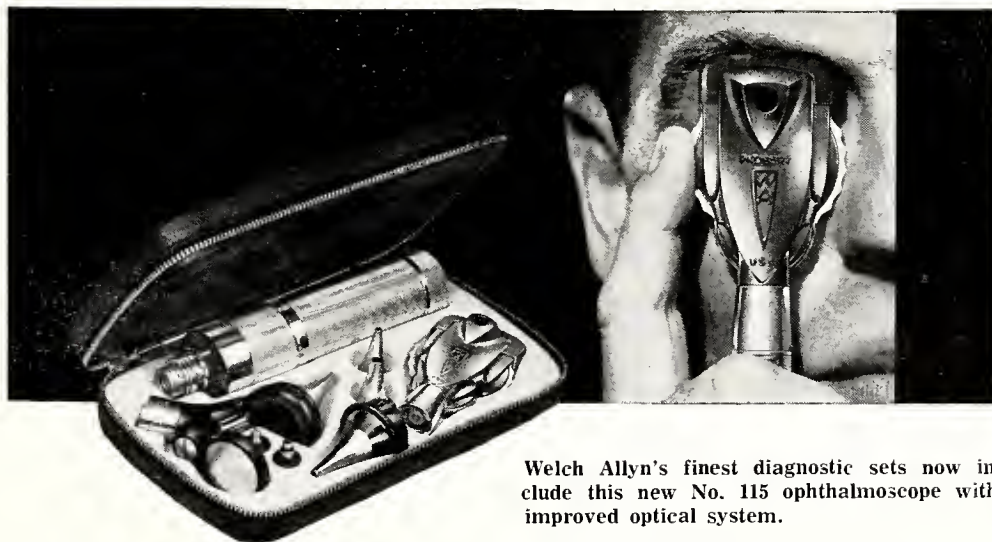
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VOLUME 27

AUGUST, 1966

NUMBER 8

Trends in Infant Mortality in North Carolina, 1933-1966

THEODORE D. SCURLETIS, M.D., KATHRYN SURLES, M.Ed.
JAMES F. DONNELLY, M.D.,* AND JAMES R. ABERNATHY, Ph.D.
RALEIGH

In 1962 the North Carolina State Board of Health analyzed the state's infant and neonatal mortality for the years 1933-1959,¹ and compared the trend in North Carolina with that in the United States as a whole.² In an attempt to account for the changing trends observed in infant mortality, the North Carolina data for the years 1952-1959 were examined in greater detail.

The present report extends the original data to include an additional four years (1960-1963) and points up the changes that have occurred since 1959.

This report, as well as the previous one, is based on information tabulated directly from birth and death certificates filed with the N. C. Department of Vital Statistics, the causes of death being coded according to the leading contributory factor reported by the attending physician or coroner. The possibility that an element of error is introduced by the information contained on these certificates cannot be eliminated.

For the reader who is not familiar with the terminology used in reporting vital statistics, it might be well to define some of the terms employed. *Infancy* and *infant* refer to the first year of life; *neonatal* and *newborn* to the the first 27 days of life; *postneonatal*, to the period between the twenty-seventh day and the end of the first year. Dates given are always inclusive.

In the graphs accompanying this article,

From the North Carolina State Board of Health, Raleigh, and the School of Public Health, University of North Carolina, Chapel Hill.

*Dr. Donnelly died on June 24, 1966.

the slopes of the trend lines were computed by the method of least squares. The points of inflection were selected arbitrarily after an examination of the plotted data.

Infant Mortality Trends Since 1933

For the first 14 years of the period under consideration, infant mortality declined rapidly, both in North Carolina and in the United States as a whole. In North Carolina

For editorial comment see page 389

(Fig. 1) the rate decreased about 5% per year from 1933 to 1947; from 1948 through 1959, the rate of decline dropped to 1.3% per year. The effect of including the four additional years (1960-1963) has been to reduce still further the rate of decline since 1947 to 1% per year.

The period of rapid decline in the infant death rate was considerably longer for whites than for nonwhites. Largely because the non-white infant mortality rate was higher in 1963 than in the two previous years, non-white rates show a slight increase since 1947. Lower death rates among white infants during the past four years have changed the upward trend (2.0% per year) observed since 1954 to a slight annual decline (0.2% per year). The new downward trend in white infant deaths in North Carolina is consistent with data for the United States as a whole.³

Among white infants, *postneonatal* deaths have continued to show a downward trend since the sharp drop which occurred in 1946

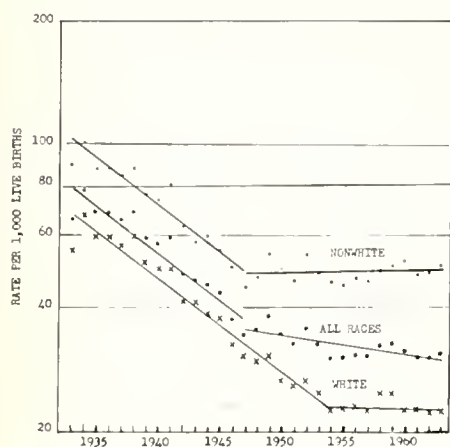


Fig. 1

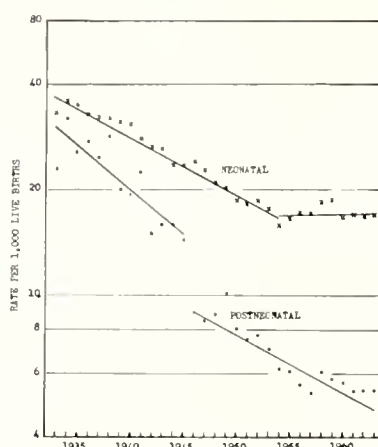


Fig. 2

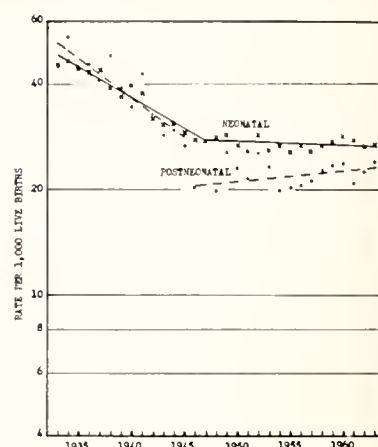


Fig. 3

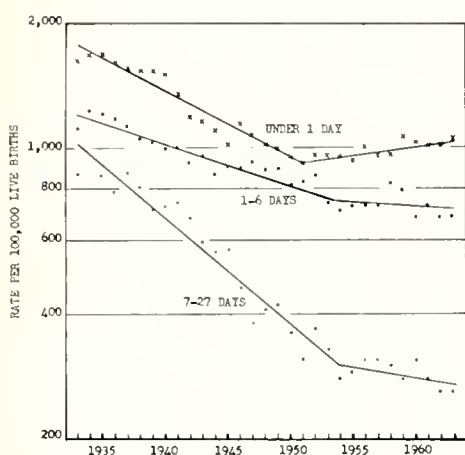


Fig. 4

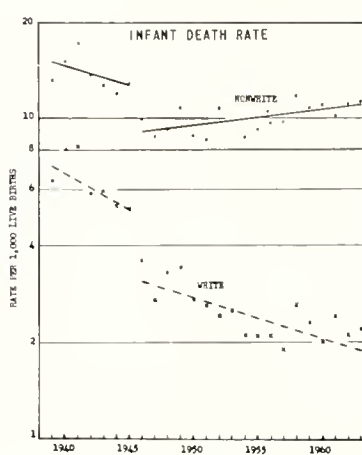


Fig. 5

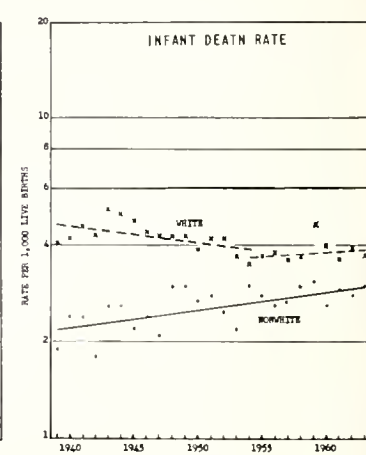


Fig. 6

Fig. 1. Infant deaths in North Carolina, 1933-1963.

Fig. 2. Neonatal and postneonatal deaths among white infants in North Carolina, 1933-1963.

Fig. 3. Neonatal and postneonatal deaths among non-white infants in North Carolina, 1933-1963.

Fig. 4. Neonatal death rate in North Carolina, by age at death, 1933-1963.

Fig. 5. Death rates from influenza and pneumonia in white and nonwhite infants in North Carolina, 1933-1963.

Fig. 6. Death rates from congenital malformations in white and nonwhite infants, 1933-1963.

Broken lines have the same significance as unbroken lines; they are used to avoid confusion where two trend lines overlap.

(fig. 2). The *neonatal* death rate for the white race, on the other hand, has increased slightly since 1954 (0.3% per year), although there has been a leveling off in the

last four years. Opposite trends are observed in the nonwhite data (Fig. 3). Neonatal deaths continue downward, although at a decelerated rate after 1946, while *postneonatal* rates have begun to rise since 1946. The continuing increase in postneonatal deaths among nonwhites in North Carolina is a matter of considerable concern, and one which seems to warrant the more detailed study given it in the accompanying article.⁴

Figure 4 shows neonatal deaths in North Carolina by age at death. Deaths occurring in the first 24 hours show an upward trend after 1950, while mortality rates for the other two neonatal age groups have continued to decline slowly since 1954, the annual rates of decline being 0.5% for infants 1-6 days old, and 1.2% for infants 7-27 days old. Favorable rates during the past four

years are responsible for this downward trend.

As can be seen in Figures 5 and 6, inclusion of the 1960-1963 data has produced little difference in the trend lines for deaths due to influenza and pneumonia and to congenital malformations. In both races, deaths from influenza and pneumonia showed a precipitous drop between 1945 and 1946. This decline is probably responsible to a large extent for the sharp decrease in postneonatal death rates observed at that time (Fig. 2). Since 1946, deaths from influenza and pneumonia have increased among nonwhite infants and continue to decrease among white infants. Deaths from congenital malformations have shown an upward trend in white infants since 1954, and in nonwhites since 1938.

The data presented in Figures 1-3 show that the rate of decline in infant deaths in North Carolina has decelerated since 1947. This deceleration occurred around 1947 among nonwhite races and around 1954 for the white race. While the trend in infant mortality for non whites is upward slightly after the point of inflection, inclusion of the 1960-1963 data has caused the trend for white infant deaths to level off; in the absence of these last figures, the white trend was also upward. For both races combined, the rates have declined at a decelerated rate of 1.0% per year since 1947.

Extension of the data to include the years 1960-63 has served to change the direction of the trend in *neonatal* death rates; rates are downward for infants dying in the first 24 hours, and the total neonatal rate shows only a slight upward trend. Additional data have also decelerated the rate of increase in deaths due to congenital malformations among white infants.

As a result of extending the data to include four more years, the trends observed in North Carolina infant mortality have become more similar to trends observed for the country as a whole.³ The greatest deviation is in the area of nonwhite postneonatal deaths, where the trend is downward for the United States as a whole, but upward in North Carolina.

*Infant Mortality Since 1952**

Figure 7 shows neonatal and postneonatal death rates by cause of death, age at death, and race. If the death rate for any age group is less than 0.1 per 1,000 live births, it is omitted from the graph.

Infections include meningitis, upper respiratory infections, influenza and pneumonia, colitis, gastroenteritis, and other infectious and parasitic diseases. Death rates from these causes are considerably higher for nonwhite than for white infants and are highest in the postneonatal period. While the rates declined for both white and nonwhite races in 1959, they rose again in subsequent years. *Congenital malformations* include causes usually considered in this category as well as bone and joint diseases. The infant death rates from these causes have changed but slightly during the entire period covered by the graphs. Rates are highest in the neonatal period. The present trend in early neonatal mortality is upward for nonwhite infants, but downward for white infants since 1959. The postneonatal death rate for white infants also began to drop in 1959, but rose again in 1963.

Birth injuries include intracranial and spinal injuries and other traumatic conditions of birth directly related to death. In the white race neonatal deaths due to birth injuries have declined since 1959, particularly in the age group from 1 to 6 days. Rates for nonwhites are slightly downward throughout the entire period, except in 1963, when the rates for infants under 1 day old and for the whole neonatal period (0-27 days) began to rise. *Postnatal asphyxia* includes all cases of postnatal asphyxia and atelectasis not related to other significant disease. The trend in postnatal asphyxia rates among nonwhite newborns is upward for the period, although there has been a leveling off since 1960. For white newborns,

*Although the rates examined in this section cover the last 12 years shown in previous graphs, the rates are not necessarily the same. Rates previously shown were based on birth and death certificates received during the year specified, regardless of the year in which the event occurred. Rates referred to in this section are based upon deaths reported among infants born during the year specified.

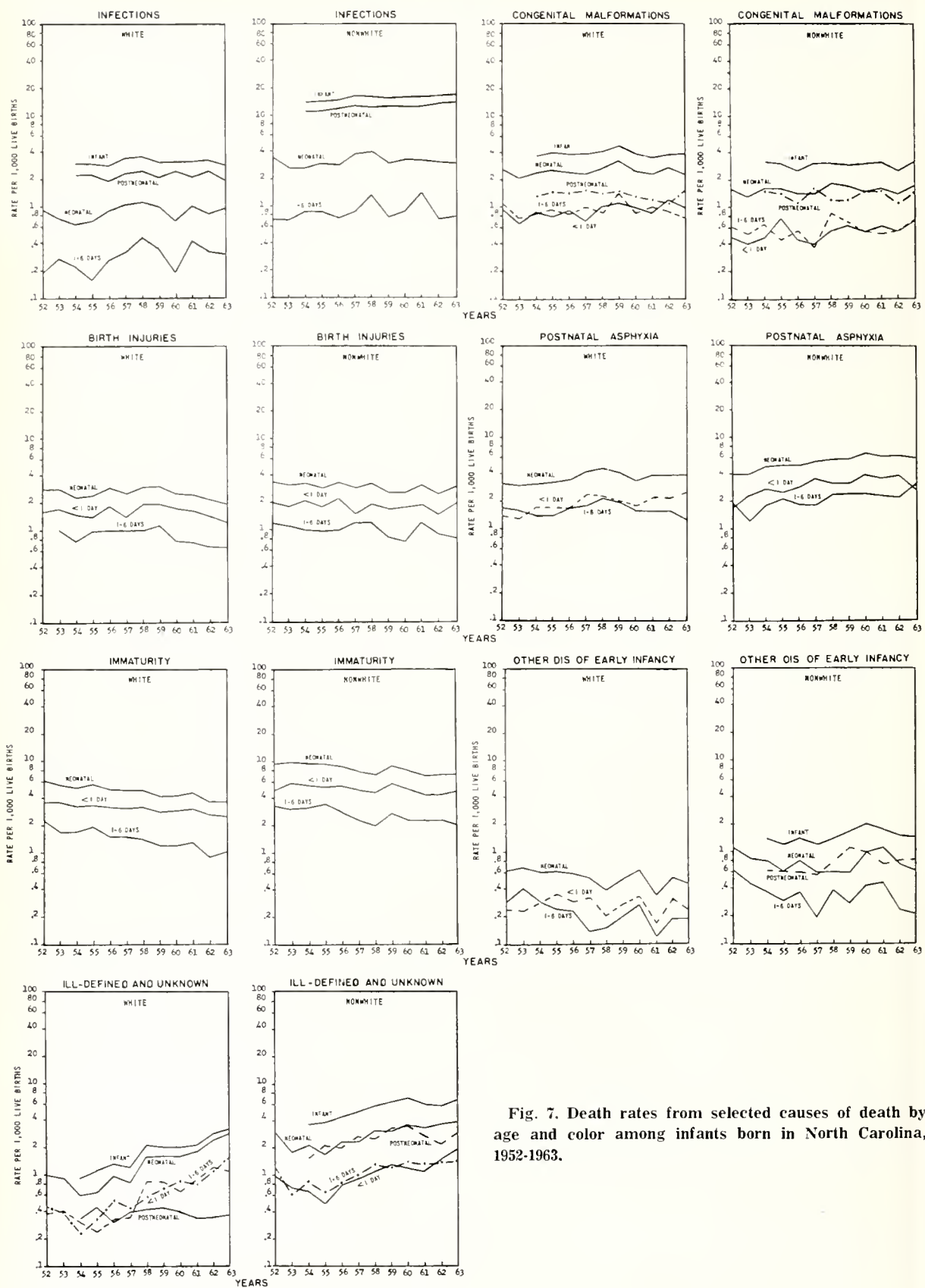


Fig. 7. Death rates from selected causes of death by age and color among infants born in North Carolina, 1952-1963.

Table 1
Deaths Among Infants Born in North Carolina, 1959-1963

Causes of Death*	Total		White		Nonwhite	
	Neonatal	Post-neonatal	Neonatal	Post-neonatal	Neonatal	Post-neonatal
All causes	11,114	5,865	6,391	2,004	4,723	3,861
Immaturity ^a	2,834	75	1,501	18	1,333	57
Postnatal asphyxia & atelectasis	2,518	25	1,445	10	1,073	15
Birth injuries	1,379	7	900	6	479	1
Ill-defined and unknown ^b	1,367	650	764	142	603	508
Congenital malformations	1,248	731	972	500	276	231
Infections	896	3,073	335	816	561	2,257
Meningitis ^c	24	96	14	37	10	59
Infective & parasitic ^d	36	234	16	88	20	146
Acute upper respiratory infection ^e	13	90	1	24	12	66
Influenza & pneumonia ^f	581	2,051	230	571	351	1,480
Gastroenteritis & colitis ^g	143	596	28	94	115	502
Other infections of newborn ^h	99	6	46	2	53	4
Other diseases ⁱ	325	166	186	13	139	153
Accidents	118	558	35	217	83	341
All other	429	580	253	282	176	298

*Superscript letters refer to footnotes giving the code number in the Manual of the International Statistical Classification of Diseases, Injuries and Causes of Death (WHO, Geneva, 1957, Seventh Revision), as follows:

- a. 774-776
- b. 773, 780-795
- c. 340
- d. 001-138
- e. 470-475
- f. 480-493, 763
- g. 5710, 764
- h. 765-768
- i. 770-772

in both races. Postneonatal deaths in this category also increased until 1959, but have shown a decline during the past several years.

During the last five years of this study (1959-1963) three leading causes (immaturity, postnatal asphyxia, and birth injuries) accounted for 61% of all deaths among newborns in North Carolina (Table 1). Ill-defined and unknown causes ranked fourth, and congenital malformations and infections ranked fifth and sixth; infections accounted for only 8% of the deaths. Of these six leading causes of neonatal deaths, only one has continued to show a definite upward trend in the white race since 1959. Among nonwhite races, however, only one of the leading causes (immaturity) shows a downward trend. It is encouraging, however, that death rates for malformations, injuries, and infections, which previously showed an upward trend in nonwhite newborns, have stabilized in recent years.

Infections, predominantly influenza and pneumonia, have accounted for 52% of the postneonatal deaths occurring since 1959. The second leading cause of postneonatal mortality was congenital malformations, which were blamed for 12% of the deaths. Among white infants postneonatal deaths due to infections have become stabilized

the rate rose slightly from 1952 through 1958, after which it decreased, then stabilized.

Immaturity includes all deaths of infants weighing less than 5 pounds 8 ounces which could not be attributed to any other cause. Although approximately one fourth of all neonatal deaths occurring in the past several years have been attributed to immaturity (Table 1), deaths from this cause, in both white and nonwhite infants, have decreased more rapidly since 1952 than deaths from any other cause. The decline is most apparent in the group of white infants 1 to 6 days of age. *Other diseases of early infancy* include hemolytic and hemorrhagic disease, nutritional and metabolic disease, and other causes not previously classified. All deaths not classified in other categories are listed as due to *ill-defined and unknown causes*. The neonatal death rate for ill-defined and unknown causes has increased throughout the period

since 1959, but in nonwhite infants the trend continues upward. Following a downward trend which began in 1959, the white postneonatal death rate from congenital malformations rose in 1963; among nonwhite infants, the rate for 1963 was almost identical with that for 1954. The nonwhite postneonatal death rates for other diseases and ill-defined causes have declined since 1959.

Conclusion

The data obtained since the last report on this subject,¹ which was based on statistics compiled for the period from 1933 to 1959, are somewhat encouraging. While upward trends exist for some causes of both neonatal and postneonatal deaths in both races, the general picture for most leading causes is that of a leveling off or even a slightly downward trend. Neonatal deaths among white infants have declined slightly since 1959, and the death rate for nonwhite newborns appears to have leveled off during these five

years. In the postneonatal period, infections have caused an increasing number of deaths since 1954 among white infants, however, this upward trend has leveled off since 1959.

While the data obtained since 1959 do not show any marked downward trend in infant mortality in North Carolina, they at least reverse the upward trends noted for most leading causes prior to 1959. The most promising area for action would appear to be in reducing the mortality from infections among nonwhite infants. This area is under study at the present time.

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Postneonatal Deaths in North Carolina, 1959-1963

EARL SIEGEL, M.D., THEODORE D. SCURLETIS, M.D.

JAMES R. ABERNATHY, PH.D., AND KATHRYN B. SURLES, M.ED.

RALEIGH

Data presented in the accompanying article¹ indicate that the disturbing upward trend in infant mortality in North Carolina has been arrested and perhaps reversed during the five-year period from 1959 through 1963. Neonatal mortality showed a slight decline in the white race during these five years and at least a leveling off in nonwhite races. In North Carolina during this period,² as in the United States as a whole,³ the neonatal mortality rate in nonwhite races was approximately one and one half times that among white infants (Table 1).

Postneonatal mortality trends follow a different pattern. Postneonatal mortality for nonwhite races has increased rather sharply in the past few years, being four times that for the white race during the period under

study (Table 1). The race differential in postneonatal mortality rates in North Carolina is considerably greater than that for the country as a whole. More than 1000 postneonatal deaths occur each year in North Carolina.

Great excesses in infant deaths occurring after the first 27 days of life were characteristic of the period before 1930 in the United States and are now found in relatively underdeveloped countries. Whereas neonatal mortality is commonly associated with deleterious biologic factors,^{4, 5} prevailing medical opinion^{6, 7} holds that a major portion of postneonatal deaths are related to unfavorable environmental situations: poor nutrition, sanitation, housing, and medical care. The present study, utilizing vital data, seeks to explore the reasons for North Carolina's relatively unfavorable postneonatal mortality in comparison with that of other states.

From the North Carolina State Board of Health, Raleigh, and the School of Public Health, University of North Carolina, Chapel Hill.

Table 1
Neonatal and Postneonatal Mortality in North Carolina and the United States
(1959-1963)

	Neonatal Deaths per 1000 Live Births (Birth—27 days)			Postneonatal Deaths per 1000 Live Births (28 days—1 year)		
	Total	White	Nonwhites	Total	White	Nonwhites
North Carolina ²	20.3	17.1	27.1	11.0	5.5	22.9
United States ³	18.5	17.0	26.6	7.1	5.6	15.6

Causes of Death in the Postneonatal Period

Information obtained from death certificates indicates that infections have accounted for slightly more than half (52.4%) of the postneonatal deaths occurring in the five years under study (Table 2). The most common type of infection was influenza and pneumonia, followed by gastroenteritis and colitis, infective and parasitic disease, meningitis, and acute respiratory infections, in that order of frequency. Infections were responsible for a greater percentage of the postneonatal deaths among nonwhite infants (58.5%) than among whites (40.7%). The postneonatal death rate from infections in nonwhite infants was 13.4—more than five and one half times as great as that in the white race (2.2). The difference in the two rates can be attributed almost en-

tirely to influenza and pneumonia, together with gastroenteritis and colitis. It can be seen in Table 2 that the nonwhite infant was six times more vulnerable to death from influenza and pneumonia and ten times more vulnerable to death from gastroenteritis and colitis than the white infant.

The next most common cause of postneonatal mortality—congenital malformations—was relatively more important in the white race, being responsible for approximately 25% of white deaths and only 6% of nonwhite deaths. The risk of death from congenital malformations was the same for both races, however, since the postneonatal death rates were identical (1.4).

Ill-defined and unknown causes ranked third in importance, with postneonatal death rates of 3.0 in the nonwhite races and 0.4

Table 2
Postneonatal Deaths and Postneonatal Death Rates in North Carolina
by Race and Cause of Death
(1959-1963)³

Cause of Death*	Total		White		Nonwhite	
	No.	Rate**	No.	Rate***	No.	Rate****
Infections ^a	3,073	5.7	816	2.2	2,257	13.4
Influenza-pneumonia ^b	2,051	3.8	571	1.5	1,480	8.8
Gastroenteritis and colitis ^c	602	1.1	96	0.3	506	3.0
Congenital malformations ^d	731	1.4	500	1.4	231	1.4
Ill-defined and unknown ^e	650	1.2	142	0.4	508	3.0
Accidents ^f	558	1.0	217	0.6	341	2.0
Mechanical suffocations ^g	257	0.5	94	0.3	163	1.0
All other	853	1.6	329	0.9	524	3.1
Total	5,865	10.9	2,004	5.4	3,861	22.9

*International Statistical Classification
a. 001-138, 340, 470-475, 480-493, 543, 572, 571.0, 763, 764
b. 480-493, 763
c. 543, 571, 572, 764
d. 750-759
e. 773, 780-795
f. 800-802, 840-962 (Excludes motor vehicle accidents)
g. 924-925

**Based on 537,979 survivors of the neonatal period and expressed as deaths per 1000 neonatal survivors.
***Based on 369,143 neonatal survivors and expressed as deaths per 1000 neonatal survivors.
****Based on 168,836 neonatal survivors and expressed as deaths per 1000 neonatal survivors.

Table 3
Neonatal Survivors and Postneonatal Death Rates in North Carolina
by Race and Age of Mother
(1959-1963)

Mother's Age	Total		White		Nonwhite	
	Neonatal Survivors*	Rate**	Neonatal Survivors*	Rate**	Neonatal Survivors*	Rate**
<15	1,849	31.4	400	10.0	1,449	37.3
15-19	102,825	16.3	64,010	7.7	38,815	30.4
20-24	184,470	10.3	132,810	5.5	51,660	22.7
25-29	125,992	8.9	90,885	4.5	35,107	20.2
30-34	73,938	8.6	50,312	4.2	23,626	18.0
35-39	38,072	9.1	24,133	4.4	13,939	17.4
40+	10,795	11.0	6,575	5.9	4,220	19.0

*Survivors of the neonatal period
**Per 1,000 neonatal survivors

for white infants. Although the significance of these differences is difficult to interpret, it is well known that sudden, unexplained death in infancy is often associated with lack of medical attention at the time of death.

Accidents (excluding those involving motor vehicles) ranked fourth, being responsible for approximately 10% of the postneonatal deaths in each race. The postneonatal death rate from accidents, however, was three times as great in nonwhites as in whites. Mechanical suffocation, for example, was four times more likely to occur in non-white infants than in white infants.

Factors Affecting Postneonatal Mortality
Maternal age

In both races, the risk of postneonatal death was greater in infants born to younger mothers, particularly to mothers under 20 years of age. For the infants of mothers under 15, the postneonatal death rate was three times as high as for those whose moth-

ers were 20 to 24 years old (Table 3). Beginning with age 20, the risk of postneonatal mortality decreases gradually as maternal age increases up to 35 years, when it begins to rise again in the white race; in nonwhite races, the decline continues to age 40.

Infants born to young mothers of nonwhite races suffer relatively higher postneonatal mortality than do their white counterparts.

Maternal parity

Despite the significantly greater risk of postneonatal death among infants born to mothers under 20 years of age, the postneonatal mortality rate is lowest for first-born infants of both races (Table 4). Among nonwhites, it is highest for the second-born; in the white race, it rises with each successive birth, with the exception of the fifth. The added risk is of such magnitude that the mortality rate for white infants of birth order six or above is more than twice that for firstborn white infants.

Table 4
Neonatal Survivors and Postneonatal Death Rates in North Carolina
by Race and Parity of Mother
(1959-1963)

Parity	Total		White		Nonwhite	
	Neonatal Survivors*	Rate**	Neonatal Survivors*	Rate**	Neonatal Survivors*	Rate**
1	149,076	7.8	113,518	4.2	35,558	19.5
2	124,848	9.7	96,124	4.9	28,724	25.6
3	90,472	10.1	67,402	5.3	23,070	24.1
4	60,446	12.1	41,512	7.1	18,934	23.1
5	38,562	13.6	22,876	6.3	15,686	24.2
6+	74,449	17.7	27,636	9.4	46,813	22.6

*Survivors of the neonatal period
**Per 1,000 neonatal survivors

Table 5

Neonatal Survivors and Postneonatal Death Rates in North Carolina
by Race and Birth Weight
(1959-1963)

Birth Weight (gm)	Total		White		Nonwhite	
	Neonatal Survivors*	Rate**	Neonatal Survivors*	Rate**	Neonatal Survivors*	Rate**
1500 or less	2,482	58.4	1,171	34.2	1,311	80.1
1501-2000	8,270	45.6	4,434	21.4	3,836	73.5
2001-2500	31,038	25.9	17,420	14.5	13,618	40.5
2501-3000	112,383	14.1	69,844	6.8	42,539	26.1
3001-3500	208,661	8.8	145,201	4.6	63,460	18.3
3501-4000	133,838	6.3	100,361	3.6	33,477	14.3
4001+	41,024	6.7	30,584	3.7	10,440	15.3

*Survivors of the neonatal period

**Per 1,000 neonatal survivors

Birth weight

It is recognized that low birth weight and, to a somewhat lesser extent, very high birth weight (above 4000 Gm) tend to increase neonatal mortality rates.^{8, 9, 10} That the mortality rate for infants of low birth weight remains high during the postneonatal period¹¹ is often overlooked when these infants are discharged from the hospital. Table 5 shows that postneonatal mortality among very small white infants (those weighing less than 1500 Gm at birth) was some seven times that of infants weighing more than 2500 Gm. In nonwhite races the postneonatal mortality rate for very small infants was even higher, being nearly two and one half times that of the white group and approximately four times higher than the rate for nonwhite infants weighing more than 2500 Gm at birth. It is interesting to note that the risk of postneonatal death is apparently not increased in infants of *high* birth weight (more than 4000 Gm.).

Illegitimacy

The recent increase in illegitimacy, espe-

cially among nonwhites,¹² has been of great concern to many professional disciplines, since the consequences of birth out of wedlock may be quite deleterious to the infant's future physical, mental, and social well-being. Postneonatal mortality rates among illegitimate children, however, are not so high as might be expected (Table 6). The risk of postneonatal death for nonwhite infants born illegitimately is only one and one half times as great as for those born in wedlock. Among white infants, the risk is almost twice as great for those born out of wedlock. It would appear, therefore, that illegitimacy as a factor in postneonatal mortality is relatively more important within the white group.

Discussion

Although deaths in the postneonatal period account for only a quarter of North Carolina's infant mortality, they deserve more attention than they have received in recent years. At the same time that the gap between white and nonwhite races has closed slightly in the field of neonatal mortality, it has widened where postneonatal mortality

Table 6

Neonatal Survivors and Postneonatal Death Rates in North Carolina
by Race and Legitimacy of Birth
(1959-1963)

Status	Total		White		Nonwhite	
	Neonatal Survivors*	Rate**	Neonatal Survivors*	Rate**	Neonatal Survivors*	Rate**
Legitimate	487,473	9.3	360,209	5.3	127,264	20.6
Illegitimate	50,506	26.2	8,934	9.0	41,572	29.9

*Survivors of the neonatal period

**Per 1,000 neonatal survivors

is concerned. Does this finding imply that environmental factors have operated to prevent full application of present knowledge and technology during the postneonatal period?

Another consideration drawing attention to postneonatal mortality is North Carolina's standing relative to the rest of the country. Whereas 13 states had neonatal mortality rates equal to North Carolina's or higher, only 6 states had less favorable rankings for postneonatal mortality in the period under study.^{2, 3}

We recognize the limitations of this review. Some are associated with the reporting of several items found on infant death certificates—in particular, those related to the cause of death. In many cases (25% for whites and 41% for nonwhites) death certificates were completed by coroners who were not physicians. Even when the death certificates were completed by physicians, it was not known for certain what proportion of these physicians attended the infants during their fatal illness or how often an autopsy examination was obtained. Another limitation of this report is the fact that the factors studied—cause of death, maternal age, parity, birth weight, and illegitimacy—were analyzed singly in their relation to mortality. In a future study, the effect of various combinations of these factors will be considered. Despite the foregoing limitations, a few worthwhile clues pertaining to postneonatal mortality were uncovered.

The dramatic decline in postneonatal mortality which occurred in the second half of the 1940's reflected the decrease in deaths from infections of all types. Although it is usually assumed that the widespread use of antimicrobial agents accounts for this decrease, it is possible that the gradual improvement in housing, nutrition, and sanitation may also have played a part. During the period of study (1959-1963) postneonatal deaths attributed to infections were more prevalent among nonwhite infants, those born to mothers of high parity, and those born out of wedlock. Accidental deaths, particularly those due to mechanical suffocation, also were more common among nonwhite infants.

Although one can do no more than speculate about deaths recorded as due to mechanical suffocation or to ill-defined and unknown causes, they probably represent a portion of the baffling group termed "sudden unexplained deaths in infancy." Rosa¹² reviewed reports of epidemiologic and pathologic investigations of such deaths from Cleveland, Los Angeles, Detroit, and the United Kingdom. On the basis of these reports and his own analysis of 1035 certificates of infant deaths occurring outside the hospital in Washington, D. C., he feels that the etiology of these deaths overlaps, to some extent, with that of deaths attributed to respiratory infections. He estimates that "sudden unexplained" and "obscure respiratory" deaths, taken together, may account for 56% of infant deaths not related to pregnancy.

It is not surprising that the postneonatal mortality rates associated with congenital malformations were the same for both races, since the factors responsible for such malformations are biologic rather than environmental. Malformations may be identified less often among nonwhites, however, and expert care may be less readily available to them. One would expect that the latter factor would allow more of these deaths to occur in the neonatal period.

From the data given, there is little question that the risk of postneonatal death is greater among nonwhite infants, among infants born to very young mothers of both races, and among infants of low birth weight. Excess parity and illegitimacy also play important roles.

If the preceding limited interpretations of existing data are assumed to be valid, what approach should we take to lowering postneonatal mortality in the high-risk groups? Will we need to wait for gradual improvement in general education to result in better income, nutrition, housing, and sanitation in these groups? Do we need earlier and better sex education in public schools, augmented by increased availability of effective contraceptive methods? Are more extensive and intensive considerations of "mothercraft" needed in junior and senior high schools? What can be expected from making medical care more generally available and

accessible? What determines its utilization by high-risk groups? How well do these mothers understand and follow through on medical instructions? Do they appreciate warning signals of serious illness? Do selected mothers in the high-risk groups feel less able to control events relating to themselves and their infants and feel more isolated and alienated from today's complex, demanding society?

Since the answers to these questions obviously require more pertinent data than are reported on birth and death certificates, it is hoped that special studies designed to yield new and more penetrating information about factors related to this important segment of infant mortality can be planned and carried out in North Carolina. Only when such data are available can we initiate more effective programs for the reduction of high postneonatal mortality.

Summary

This review of vital data indicates that North Carolina's failure to make substantial reductions in infant mortality during the five-year period 1959 through 1963 is related largely to a relatively high postneonatal mortality.

More than half of the postneonatal deaths were attributed to infections, principally influenza and pneumonia, gastroenteritis and colitis. Other causes listed by those completing the death certificates were, in order of decreasing frequency, congenital malformations, ill-defined and unknown causes, and

accidents (excluding those related to motor vehicles).

Postneonatal mortality was found to be highest among nonwhite infants, infants born to young mothers, and infants born to mothers of high parity. Low birth weight and illegitimacy were two other factors associated with high postneonatal mortality.

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There is much to be gained in most instances by labelling the nature of the medication. Patients are bombarded on all sides by medical information, their approach to medical care is much more sophisticated than that of their parents. The growth of effective pharmaceutical agents has been such that three or four types of medication may be indicated for the management of a single problem. Labelling promotes better medical care rather than detracting from it. Labelling also promotes more effective communication between the patient and the physician.—E. Clinton Texter, Jr., M.D., *Illinois Medical Journal*, (129:270), March 1966.

Abdominal Pregnancy – Still a Paradox

Report of a Case with Survival of Infant

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Thanks to modern medicine, we are now beginning to see a revival of abdominal pregnancy—a rare entity described more than a thousand years ago by Albucasis.

Incidence

With the advent of antibiotic therapy for pelvic inflammatory disease, ectopic gestations have increased to the point that the incidence is about 1% of all pregnancies.¹ The number of advanced extrauterine pregnancies might be expected to increase correspondingly, since probably 1% of all ectopic pregnancies reach term. In 25 cases recently presented by Barnett and Bolen,² and in 65 cases reported by Beacham and colleagues,³ the proportion of ectopic pregnancies to all deliveries was 1:3244 and 1:3166 respectively.

In a review of the American literature prior to 1961, Bright and Maser⁴ found 12 survivals, with a 10:1 ratio of nonwhite to white cases. They concluded that the possibility of obtaining a living infant was extremely small. The consensus in the literature is that an infant has about a 25% chance of surviving and a 10% chance of being normal. Schluskel and Sall⁵ reported one five-year survival (nonwhite) in 1964. Henderson and Wilson⁶ reported one survival in 10 cases encountered between 1943 and 1961. Boyd⁷ added an 11-year survival (white) in 1965.

Mortality

Beacham and others³ reported a fetal mortality of 94% in 229,164 cases. Yet 27 years earlier (1935), Helmann and Simon⁸ tabulated 311 cases extending from 1809 through 1933, and added 5 cases of their own; the fetal mortality in the 316 cases was 50%. Classified as "lived," however, were babies surviving eight days or longer. And in 1948 Ware⁹ documented 149 cases gathered since

the 1935 report, and presented 5 new cases; the fetal mortality rates of the two series were 95.5% and 38.5% respectively. In his discussion of this paper, Douglass claimed an overall fetal mortality rate of 77% in a series of 26 cases collected over a 25-year interval in all Baltimore hospitals.

Diagnosis

From a review of the literature from 1964 through 1965, it would appear that an isolated case of abdominal pregnancy with a viable fetus is reported almost monthly. The fact remains, however, that the diagnosis continues to be missed with alarming frequency. The possibility of abdominal pregnancy should be considered whenever bizarre circumstances are encountered in obstetrics. It must be included in the differential diagnosis of every patient in the reproductive age group who presents any combination of the following symptoms: abdominal pain, irregular vaginal bleeding, amenorrhea, nausea, vomiting, atypical or painful fetal movements, weakness or fainting, and "atypical labor." In the presence of tenderness, an abdominal mass inconsistent with that of a normal pregnancy, abnormality of the cul-de-sac or fetal lie, or displacement of a long, firm, effaced cervix, abdominocyesis must be ruled out.

A review of the radiologic literature reveals surprisingly few articles on this subject.^{10, 11} Weinberg and others¹¹ have given eight signs of the radiologic diagnosis of extrauterine pregnancy.

1. Abnormal position and presentation of the fetus—usually the oblique or transverse position. Often the position is eccentric, with displacement from the midcoronal plane.
2. Absence of the gravid uterine and placental shadows in their "normal position."
3. Unusual sharpness and clarity of the fetal parts.

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4. Intermingling of the maternal gaseous shadows with the fetal parts.
5. Unchanging position of the fetus on serial films.
6. Presence of a pelvic or lower abdominal mass.
7. Close proximity of the fetus to the maternal spine on lateral projections when evidence of maternal bowel obstruction is lacking.
9. Calcification of the amniotic sac and signs of fetal death (may be present in extrauterine pregnancy).
10. An empty uterus demonstrated by hystero-gram (for academic purposes only).

Case Report

An expectant mother, a 35-year-old Negro woman, gravida 5, para 1, abortus 2, and ectopic 1, was admitted to the Duval Medical Center Hospital in December 1964, for management of pre-eclampsia. Her last menstrual period had occurred on March 27, 1964, and at the time of her first clinic visit four months later, her weight was 200 pounds and blood pressure 120 systolic, 80 diastolic. On October 19, 1964, she had a urinary tract infection which responded well to sulfisoxazole (Gantrisin); however, this episode was followed by the beginning of generalized discomfort and later by the gradual onset of edema.

At the patient's regular clinic visit on Dec. 17, 1964, an abrupt elevation of blood pressure to 180/90 was noted, and she was immediately hospitalized. Vaginal examination at this time disclosed a long, closed uneffaced, and undisplaced cervix. An attempt to induce labor with oxytocin (Pitocin) failed, and x-ray studies were made to determine fetal size and position. These indicated a fetus at term, in normal position with vertex presentation, the skull not engaged, yet not abnormally high in the pelvis. A density indicating a homogeneous mass of soft tissue to the left of the fetal skull suggested either placenta or uterine fibroid. However, placental and uterine shadows were thought discernible, the fetal parts were not remarkably clear, there was no intermingling of maternal gas shadows, and no fetal parts overlay the maternal spine. Unfortunately the anterior abdominal wall was not included in the lateral view. Serial roentgenograms were not taken, for the very good reason that neither the radiology nor obstetric service staff suspected the diagnosis of abdominal pregnancy. The urology department did obtain a cystogram for the purpose of evaluating the possibility of placenta previa. Yet this pelvic mass encroaching upon the bladder was ultimately interpreted as a fibroid, since the placenta was still held by some to be identifiable in the abdomen.

Another trial of oxytocin failed to stimulate uterine contractions, and the cervix remained long, closed, uneffaced, and undisplaced. Although the patient's general condition improved, it was never possible to reduce

the blood pressure below 140/100. When the fetal movements appeared to become less active, a cesarean section was elected.

Operation revealed an abdominal pregnancy with viable fetus. The baby was delivered five minutes following induction of general anesthesia and required considerable nasopharyngeal aspiration and positive pressure oxygen resuscitation, yet left the delivery room, crying. Ordinarily the placenta would not have been removed; however, it was not felt possible to control the extent of hemorrhage without this maneuver. The placenta appeared to arise from a stalk (about 5 inches in diameter) extending from the region of the posterior portion of the broad ligament and cul-de-sac. There were many loops of small bowel closely adhering to the placenta, which, together with adhesions, rendered the dissection rather difficult. Nevertheless, all but a small portion of the base of the placenta was removed with no more serious trauma than a small ileal tear which was easily repaired.

The patient made a moderately uneventful recovery and was taking nourishment by mouth within four days. Her only postoperative complication was elevation of temperature (102 F maximum,) which returned to normal on the sixth day, controlled with penicillin and sulfisoxazole. Her blood pressure was stabilized at 150/100 and at the time of discharge from the hospital was 140/90.

The baby's postoperative course was somewhat more eventful. The blood type was O-Rh-positive. A Coombs test was not performed. The child required transfusions on Dec. 23, 1964, after the hematocrit level had fallen from 45% to 22%. The patient was noted to be jaundiced, and the serum bilirubin value on Dec. 25 was 8.4 mg. Following the transfusions the jaundice subsided and the hematocrit level began to approach normal—34%. A grade II systolic murmur was considered functional, and the electrocardiogram was not remarkable.

The baby was last seen on August 4, 1965, in the pediatric clinic, weighing 24 pounds 6 ounces. The mother was last seen in the gynecology clinic on Aug. 19, 1965. Both were doing well.

Discussion

It is significant that in King's classic article of 1954,¹² the x-ray examination failed to suggest that the pregnancy was extrauterine in 3 of 12 cases. In Boyd's case,⁷ the x-ray examination indicated a breech right sacrotransverse presentation, with no evidence of extrauterine pregnancy. Only 3 of Henderson's and Wilson's 10 cases were diagnosed preoperatively.⁶

A presentation of 2 undiagnosed cases by Fielding and others¹ produced several important points: (1) the diagnosis must be considered before it can be made; (2) the intravenous oxytocic diagnostic test is use-

ful; and (3) the diagnosis can be missed even when the patient is under observation in a teaching center where all modern diagnostic tools are available. A correct diagnosis before labor is induced or abdominal delivery is attempted enables the obstetrician to anticipate unusual difficulties, and consequently reduces the risk to the patient. This is true in spite of the paradox that "most of the surviving babies described in the literature were delivered by operators who thought they were performing a cesarean and to their surprise, utter amazement, in some instances, found the baby upon entering the abdominal cavity";¹³ and that astonishingly lower fetal mortality rates were reported two, and even three, decades ago. Regardless of the clinical facilities and departmental services available, the diagnosis of abdominal pregnancy can be missed and must be considered before it can be made.

Summary

A case of an extrauterine pregnancy with delivery of a living infant is presented. This ancient complication of obstetrics, somewhat more common but no less catastrophic than when first described, is discussed in references to its many paradoxes: The lower fetal mortality of the past; the higher rate of fetal survival in unsuspected cases (because

there are no complications to make one suspect it); the number of cases that continue to go undiagnosed even with all the clinical facilities available at the present time; and the expected increase of this phenomenon in the future.

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Government, the physician, and the pharmaceutical industry must join forces to reduce injury from adverse drug reactions. It is industry's responsibility to continue with the development of safer and more effective drugs. It is the responsibility of the physician to use drugs with discretion and to abstain from using potent and hazardous drugs for trivial conditions. It is the government's responsibility, with its virtually unlimited funds and resources, to continuously review and survey adverse experience gained with drugs from all sources and to bring these facts before physicians preferably through already organized channels of medical communication. The government further has a responsibility to remove overly hazardous drugs from the market when usefulness does not balance off against hazard, but it must not use this authority in an arbitrary and capricious manner. The evaluation of drugs for safety is a most difficult and complex matter, and no simple formula can be devised to arrive at a conclusive opinion.—Joseph F. Sadusk, Jr., M.D., to American College of Physicians, New York, April 19, 1966.

Tympanic Membrane Grafting with Periosteum

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The purpose of this presentation is to outline a technique which has been used successfully for the reconstruction of the tympanic membrane that has been damaged or destroyed by chronic middle-ear disease. A series of 40 cases in which a free periosteal graft was used will be reviewed. It is not the purpose of this paper to review in detail all the aspects of tympanoplasty.

At the present time fascia,^{1, 2} auditory canal skin,^{3, 4} and in some instances vein,⁵⁻⁷ are probably the most commonly used tissues for grafts in microsurgery of the middle ear, and good results may be obtained with any of them. Of the three, venous tissue is being used less at present, since consistently good results are difficult to achieve when this tissue is used to repair large perforations apparently due to excessive thinning. Chiossone⁸ reported 32 cases in which periosteum was used for reconstruction of the tympanic membrane. Mastoidectomy was required in all of his cases, and in each a defect of the ossicular chain was present. He questioned the advisability of using periosteum for transmeatal repair of the tympanic membrane when the ossicular chain is intact, or when mastoidectomy is not required. Wright⁹ felt that the use of periosteal grafts resulted in thicker tympanic membranes and poorer hearing than that observed with other methods.

During the past two and a half years I have used periosteum for reconstruction of the tympanic membrane in 64 cases. Forty of these cases have been followed postoperatively for a minimum of eight months and will be reviewed here. Twenty of the 40 patients were so treated although the ossicular chain was intact. Various repairs were carried out on the remaining 20 patients to restore communication between the drum-head and the stapedia footplate.

Active infection of the middle ear and

mastoid should be controlled completely, when possible, before surgical repair of the tympanic membrane is attempted. Removal of inflamed tissue from the middle ear, as well as mastoidectomy, may be required before a dry ear is obtained. If mastoidectomy is necessary, every effort is made to preserve the posterior bony auditory canal wall, an objective which is usually possible even when cholesteatomas are present. In my opinion, the tympanic membrane should not be repaired at the time of mastoidectomy, if the latter is required for control of drainage; the tympanic membrane should be reconstructed, in a dry ear, as a second-stage procedure. In some of these patients tympanoplasty will be contraindicated, depending on the extension and type of disease encountered at time of mastoidectomy.

In the following discussion of the repair of the tympanic membrane, it is assumed that the ear has been adequately treated, either medically or surgically, and that it is ready for the reconstruction of the tympanic membrane and, where indicated, the ossicular chain.

Techniques

The transmeatal technique used in a large central perforation utilizes a posterior canal flap, or "sling," which is elevated following a semicircular incision similar to, but wider than, the flap used to enter the middle ear for stapes surgery (Fig. 1). In certain cases it is advantageous, for the sake of exposure, to divide this flap across the central portion extending into the perforation, unless the drum head has an anterior perforation with a normal-appearing posterior half. The central incision should not be made, however, until the entire circular flap, down to the tympanic annulus, has been elevated. The tympanic annulus is also elevated and divided. After this central incision has been made, a flap can be folded above and below to give access to the middle ear (Fig. 2). The epithelium attached to the outer surface of the

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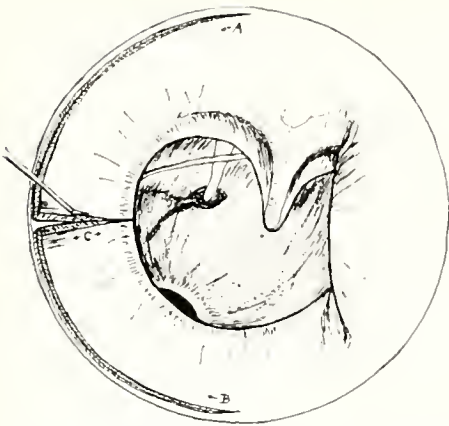


Fig. 1. Large perforation of the right tympanic membrane. Circular incision, line A to B. Flap produced in posterior auditory canal wall divided by incision, line C.

malleus is elevated superiorly to the lateral process of this ossicle, and even higher if indicated. A Wullstein or Tabb knife is used for the dissection.

In cases where the anterior margin of the tympanic membrane is obscured by overhang of the bony external auditory canal wall, a U flap is made in the anterior portion of the canal and the overhang is removed by use of a mastoid drill (Fig. 3). Bony overhang of the posterior auditory canal wall is removed by curette or drill for routine inspection of the ossicular chain.

The margin of the perforation, which is usually thickened and frequently avascular, is excised, and the medial surface of the rim of the remaining tympanic membrane is freshened for a minimum of 2 to 3 mm throughout its periphery. This completes the preparation of the middle ear except for the placement of small pieces of Gelfoam into the middle ear tissue space prior to application of the graft.

Periosteal tissue is obtained from the temporal bone and inserted underneath the flap of the posterior auditory canal wall, then pulled anteriorly and placed in contact with the undersurface of the drum margin, or rim of perforation (Fig. 4). Care is taken however, to place the graft across the outer surface of the malleus, bringing it superiorly to the lateral process of the latter. After this is done, the flap previously dissected from the malleus is placed in contact with the outer surface of the graft (Fig. 5). One must be

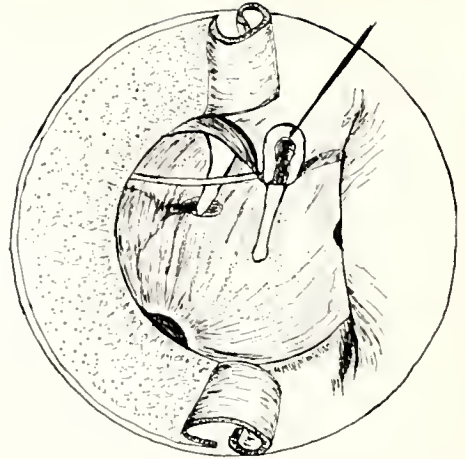


Fig. 2. Superior and inferior flaps are shown elevated from the bony posterior auditory canal wall, with the fibrous annulus elevated with flaps.

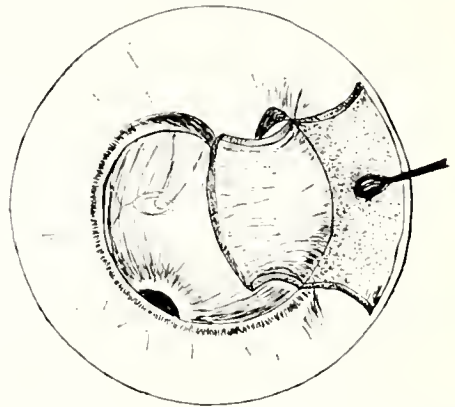


Fig. 3. A flap has been elevated and is folded medially to permit removal of bony overhang of the anterior auditory canal wall by a bone-cutting burr.

certain that the posterior portion of the graft has been placed in contact with the posterior portion of the bony auditory canal wall, underneath the "sling" or the upper and lower flaps made where the "sling" is divided.

In the presence of a large perforation involving the anterior half of the pars tensa, the posterior half of the tympanic membrane is kept intact but is dissected from the malleus to where the posterior margin of the graft extends at its support over the malleus and below the periphery of the remaining tympanic membrane (Fig. 6). In this situation, the graft is not brought posteriorly to the external auditory canal wall.

When extensive tympanosclerosis involves the remaining posterior half of the drum head, the avascular tissue is excised and

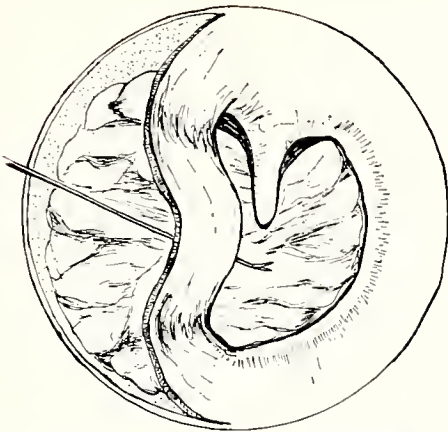


Fig. 4. Periosteal graft is being placed underneath the the posterior auditory canal flap in a case in which the "sling" was not divided. The anterior margin of the graft has been inserted underneath the fibrous annulus. The epithelial flap dissected from the malleus has been placed in contact with the outer surface of the graft and the malleus supports the graft medially.

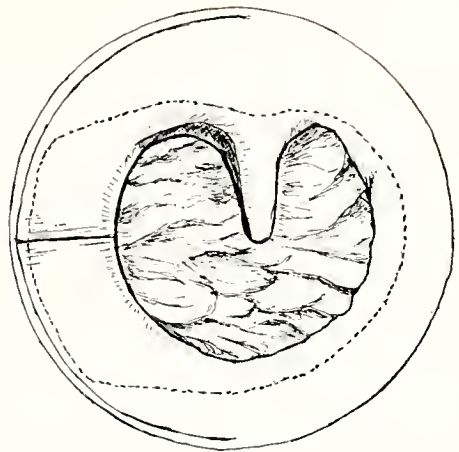


Fig. 5. Periosteal graft is seen after completion of the procedure with the skin flaps restored to their normal positions, but with the posterior margin of the graft between the bony and membranous portions of the auditory canal. The dotted line indicates the margin of the periosteal graft underneath the fibrous annulus anteriorly, the skin flaps of the auditory canal posteriorly, and the epithelial flap dissected from the malleus, superiorly.

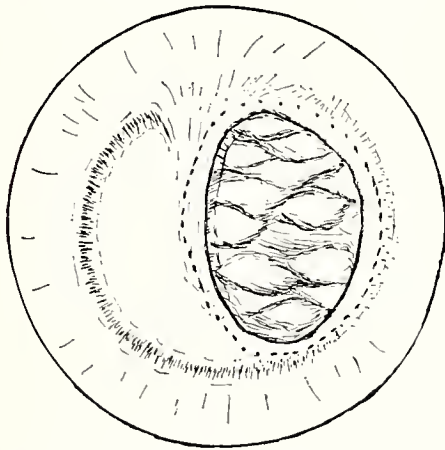


Fig. 6. An anterior perforation with the graft inserted and the margin outlined by a dotted line.

the graft is placed posteriorly, as previously described, using the flap of the posterior auditory canal wall. Posterior perforations are repaired similarly. The anterior limit of the dissection is the elevation of the remaining tympanic membrane from the malleus, the margin of the graft being placed 1 or 2 mm anterior to the outer surface of the malleus, there being positioned between the malleus and the remaining portion of the anterior tympanic membrane (Fig. 7).

Small pieces of Gelfoam are used to cover the graft and the incisions in the auditory canal wall completely. Two small pieces of

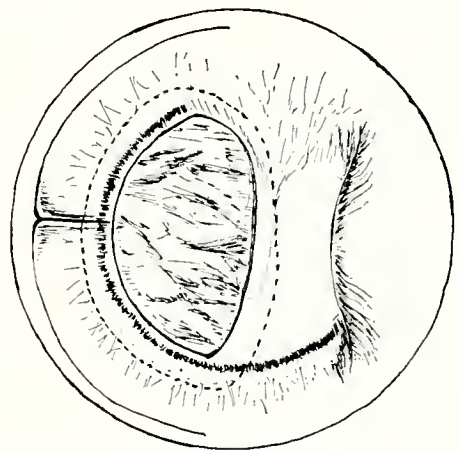


Fig. 7. A posterior perforation corrected with the graft in position extending anteriorly to the outer surface of the malleus.

loosely applied Adaptic gauze are then placed against the Gelfoam.

Results

A satisfactory "take" of the periosteal graft was evident in every case of this series of 40 patients, and good color was noted at the end of two weeks. In 4 cases a perforation later developed in the graft. Three of these perforations healed completely, with a satisfactory anatomic result. In the fourth case the opening became larger and showed

no disposition to heal. Three perforations were located centrally and one was of the anterior marginal inferior type. With the one exception mentioned previously, all perforations healed slowly on cauterization of the margins with trichloroacetic acid at weekly intervals. The earliest perforation was noted after three weeks, and the latest after seven weeks.

Two grafts healed satisfactorily without perforation, but between six to twelve months showed severe retraction, presumably because of poor function of the eustachian tube, which had not been apparent before operation. In two cases myringotomy was necessary to remove serous fluid following upper respiratory infections. The grafts healed as one would expect in a normal tympanic membrane.

Good functional hearing was obtained in 25 cases, with the air conduction curve elevated to within 10 decibels of the preoperative bone conduction curve in the speech frequencies. Satisfactory results were obtained in 10 patients, with a gap of 10 to 25 decibels in the two curves following surgery. In 3 patients, hearing was improved but remained below 30 decibels. The hearing of 2 patients was unchanged from the preoperative level, although 1 of the 2 obtained a good anatomic graft result. Of the 20 patients having an intact ossicular chain, the air-bone gap was closed in 15 and to within 10 decibels in the remaining 5.

Observations

The results in the patients with an intact ossicular chain would suggest that the thickness of the periosteal graft as opposed to the other tissues currently used for grafting techniques is not a contraindication for its use. The site at which the periosteal tissue is taken is most important, since the thickness varies considerably. When taken directly behind the auricle, at the site of the usual post-auricular incision, the graft will include deep fascial as well as periosteal tissue, which is much too thick and is difficult to separate. A good donor site is posterior to the auricle and level with the uppermost portion of the auricle, approximately 1 2 cm poster-

ior to the hairline (Fig. 8). A curved incision extending 2 cm is made and the graft readily obtained, since the periosteum is easily accessible at this site.



Fig. 8. The site at which the periosteal graft is obtained, just posterior to the hairline.

The extensive network which develops across the graft in two to three weeks is prominent and remains so for as long as six months, at which time the periosteal graft has thinned considerably to resemble, in most cases, the normal, glistening tympanic membrane. In a few of the cases reviewed here, granulation tissue developed over the outer surface of the graft during the first four postoperative weeks. This complication was easily controlled by use of trichloroacetic acid. No late perforation due to excessive thinning has been noted. The skin flaps of the auditory canal were well healed in two weeks.

Advantages

This technique insures good circulation to the periosteal graft as the strip of vascular tissue dissected from the malleus is brought down and the graft inserted between it and the malleus, from which the major blood supply of the tympanic membrane is derived.¹⁰ The posterior portion of the graft is assured a good blood supply since the skin of the auditory canal wall is restored to its normal position, but with the periosteum between the membranous and bony portions of the posterior external auditory canal wall.

The periosteal graft is much more easily manipulated than fascial graft and can be positioned in the middle ear by using a

small needle suction and ring curette without displacement by suction. A minimum of postoperative care is needed, a particular advantage in the management of children, in whom we have obtained some of our satisfactory results.

Packing is left in the auditory canal for five days only, thus obviating prolonged use of antibiotics. No postoperative strictures have been observed.

Periosteal tissue is remarkably resistant to infection. In 2 cases, infection of the middle ear, with profuse, purulent discharge leaking from an elevation of the periphery of the graft, was encountered two weeks after operation; however, no permanent damage to the graft resulted.

Periosteum has been used to great advantage to cover defects produced by removal of bone for exposure of the epitympanum. When bone is removed in order to expose the head of the malleus adequately, the body of the incus, or the aditus for removal of diseased tissue, the area can be covered completely with the same free graft used to repair the tympanic membrane defect.

Summary

Periosteum has been used to reconstruct the tympanic membrane in 40 cases where large perforations of the drumhead resulted from chronic middle ear disease. A technique in which the canal skin is preserved and the vascular supply to the tympanic membrane maintained is presented. A satisfactory ana-

tomic result was obtained in 39 cases, with complete failure in one.

Although four perforations of the graft were noted, three healed completely to give a satisfactory result. Good or satisfactory functional hearing was obtained in 35 cases, and improved but not satisfactory hearing in 3 cases. Hearing was not improved in 2 patients.

Some of the advantages of periosteal tissue for grafting procedures of the middle ear are mentioned. No real disadvantages have been noted to date.

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THE CASE OF THE THERAPEUTIC ESTABLISHMENT

Progress in the (pharmaceutical) industry depends on research and development. . . . The drug firms spent \$298 million for research in 1964, compared with \$282 million in 1963. In 1966, expenditures for research are expected to reach \$370 million. The main products concerned have been psychotropic drugs, new preparations to combat cancer and degenerative diseases, and compounds especially used by aging patients. An intensive search into the physiology of reproduction is yielding important and improved drugs in this field. —Morris Fishbein, M.D., in *Medical World News*, (7:184), March 18, 1966.

The Role of the Family Doctor in Accident Prevention

ROBERT VERNON JETER, M.D.

PLYMOUTH

In April, 1963, while driving down the road toward Plymouth, I met a truck loaded with logs. When we were about 50 yards apart, a 3-foot section of pine log fell off the truck, hit the pavement, and bounced into the air. I could see it was heading straight for me. I had a choice of running into a canal on the right of the road, hitting the log truck head-on, or letting the log hit me. Fastened in my seat by a safety belt, I could only make myself as small as possible and pray. The log came through my windshield, showering me with broken glass, hit the steering wheel, and stopped about 4 inches from my chest.

Since that day I have had more than a passing interest in the problem of highway accidents and have given it considerable thought. Also, for some ten years I have participated in various accident-study groups, including the Rural Health Committee of our State Medical Society, the North Carolina Rural Safety Council, and the North Carolina Traffic Safety Council. Thus, I have been in a position to compare accident fatality and morbidity rates in this state for a good many years.

Geographic Distribution of Accidents

Statistics show that accidents in the home are as frequent in the country as in the town, and the survival rates are almost the same. Outside the home, however, the resemblance quickly ends. In a recent California study conducted by Dr. Julian A. Waller of the California Department of Public Health,¹ it was shown that motor vehicle fatalities are more than two and one-half times more frequent in the flat agricultural counties and five times more frequent in the mountains than in urban areas. Off-the-highway deaths are almost twice as common in the

flat farm lands and about three times as common in the mountains as in cities.¹

Some of the most hazardous occupations, such as logging, farming, mining and the like, are primarily rural by their very nature, and in North Carolina's "Variety Vacationland," a good proportion of all motor accidents involve tourists and urban residents traveling or vacationing in relatively unfamiliar rural areas. Also, the rural area has the unique problem of the middle-aged farmer, in his old pick-up truck, driving 25 to 30 miles an hour down a heavily traveled secondary road. His total disregard for, or ignorance of, the necessity for smooth traffic flow as a safety factor causes traffic to back up behind him. Sooner or later someone is going to get impatient and take a chance on passing—endangering all concerned. Then we have the young "jet-set" driver off the farm, speeding down the road in a late model car—or a souped up old one—taking any chance that comes along. A review of fatal accidents listed by the North Carolina Department of Motor Vehicles discloses that many of the drivers were rural residents. Much of this irresponsibility can be blamed on parental neglect or ignorance or apathy.²

Before leaving the problem of rural accidents let me say a word about my favorite nightmare, the log truck. This outstanding hazard—common to both Eastern and Western Carolina—is of such a magnitude that most of the log-haulers I am familiar with are "assigned risks"—that is to say, no insurance carrier will voluntarily insure them. Although trucks are extremely difficult to maneuver when loaded, they are often driven by low-salaried employees who have little regard for other drivers. I have personally seen them—even been passed by them—when they were obviously driving over the posted limit. Yet only two years ago, legislation was passed in this state allowing owners to in-

Read before the Section on the General Practice of Medicine, Medical Society of the State of North Carolina, Asheville, May 3, 1966.

crease their loads in both length and height, a clumsy situation at best.¹

Alcohol and Driving

A more frequent problem in densely populated areas is posed by the drinking driver. We all know that accidents involving drinking drivers don't just happen. Alcohol is listed as the primary cause of about 40% of all traffic fatalities. In other states this figure ranges from 35% to 80%. Here we must look at the problem from two angles—that of the social drinker and that of the outright alcoholic. Socially, two or three drinks can easily arise blood alcohol levels by 30 to 100 mg/100 ml. Now, it is estimated that three-fourths of the adult population in the United States indulge in social drinking. Thus it would seem to follow that the majority of accidents involving drinking would be caused by the majority of drinking drivers—namely, the social drinkers.³

Dr. Waller found in California, however, that this expectation is not borne out by the actual pattern of such accidents. Accidents involving low blood alcohol levels (under 100 mg/100 ml) are less common than might be expected from the number of social drinkers, while extremely high levels (150 mg/100 ml or higher) are very common in accidents. McCarroll,⁴ in a New York study, implicated pathologic drinking as the cause of the higher blood alcohol levels, and concluded that pathologic drinkers comprise almost 50% of all drunken drivers, but less than 10% of the total population. This finding has been borne out by numerous other studies. Selzer,⁵ in Michigan, identified problem drinking patterns in more than 70% of a group of drunken drivers who were given psychiatric interviews. He also found that during a two-year period in Washtenaw, Michigan, more than half of 72 drivers involved in accidents suffered from some form of mental illness. Thus, he and his associates suggest that the underlying personality of the driver may play as important a role in traffic accidents as does the pharmacologic effect of alcohol. To test this hypothesis they asked 50 alcoholic drivers and 50 non-alcoholic drivers what effect alcohol had on their driving behavior. In general the alcoholics said that drinking

made them more reckless, while the social drinkers said it made them drive more carefully.⁵

Waller³ recently supported this finding by showing that the drinking accidents of alcoholic drivers occur at faster speeds than do the accidents they had while sober, whereas the drinking accidents of non-alcoholic drivers do not. Among numerous studies of accidents involving alcohol it is found that alcoholics have twice as many accidents per mile driven as other drivers, and that between 30% and 70% of drinking accidents involve problem drinking. But let us not forget the teenager who uses a car and a beer as a status symbol, and the young married adult showing off.

Other Factors Affecting Drivers

Chronic Illness

All doctors know that patients suffering from acute or chronic diseases may show significant changes in personality. The acutely ill person presents little or no problem, since he rarely appears on the highways. But what of the patient with hypertension? Or severe arthritis? Or cardiovascular defects? Couple any of these conditions with personality changes and you have a potentially dangerous situation; add alcohol to the combination and it suddenly becomes explosive. It has been shown that alcoholic drivers represent only 7% of the drivers and a little less than 8% of the miles driven, yet they are responsible for more than 50% of the accidents. Drivers with chronic medical conditions are completely or partially responsible for about two thirds of their accidents. Add alcohol and this fraction goes up to seven-eighths.⁹

Epilepsy, with its widely varying patterns, is now increasingly in the researcher's spot light. Our own Dr. John A. Morris tells about a bus driver working on a night shift who neglected to report that he had epilepsy because, he said, he had seizures only in the daytime.

There has been considerable argument as to whether drivers with *petit mal* epilepsy should be restricted. To date, no one seems to have the final answer. It appears that

petit mal carries a smaller risk than *grand mal*, but the studies are incomplete.

Other chronic disorders such as diabetes, "black-out spells" due to a variety of causes, mental illness, and the legal or illegal use of drugs are also under investigation. Right now the most that can be said is that the driving patterns of the chronically ill emerge with significantly higher accident and traffic violation rates than do those of normally healthy people. The accident rate is roughly twice that of healthy drivers. It is interesting to note that drivers with psychosocial disorders had higher traffic violation rates than those with chronic physical disorders.⁶

Age

A breakdown by age groups was conducted in California by Waller,⁷ comparing accidents per million miles and violations. In the 15- to 29-year-old group, chronically ill patients had 15.3 accidents per mile compared to only 11.0 accidents per mile for well persons. In the 30- to 49-year-old group the ratio was 12.7: 5.6; in the 50- to 59-year group it was 17.3:7.2; and over 60 years of age, the chronically ill were ahead 24.3 to 11.3.⁷

As expected, the violation rate followed the same pattern. Yet in North Carolina license examiners are forbidden to give parallel parking tests to persons 60 years old and older, one of the better tests for depth perception and feel of an automobile prohibited by law to a "special group." I have patients who have been sent home from state hospitals with diagnoses of schizophrenia, chronic brain syndrome, and other serious mental disorders who were not restricted from driving; in fact, I can find no evidence that the disorders were even reported to the Motor Vehicle Department. Over the past several years I have asked the coroners of several counties whether or not autopsies were performed on persons killed in traffic accidents. Almost invariably the answer was, "No, we have neither the time, money, nor personnel to do an adequate job in such cases." The outstanding exception is in the rare "questionable insurance" category.

What Can We Do?

Now, we must ask ourselves the important question, "What can the family doctor do to

help prevent this needless slaughter?" How can a general practitioner change any given situation, the aggregate of which is killing more than 100,000 people a year in the United States? Remember that in 1963 accidents also caused some 50 million nonfatal injuries and filled 50 thousand hospital beds in the course of the year.⁸ From the medical point of view, there's a clear parallel between accidents and disease. Medical men have conquered smallpox, plague, polio, diphtheria, tuberculosis, and other diseases, all of which were once thought to be beyond the power of human resources to control. But many groups, professions, and disciplines have been joined in great efforts to make these victories possible. The present day family doctor has neither the time nor the inclination to preach "Safety First" or enter into legislative battles. The various safety councils have tried this—unsuccessfully, I may add—for years. We even recorded programs on safety, with the help of county extension agents, and distributed them to radio stations throughout North Carolina. If the programs helped any, I have yet to hear about it. They did win several awards from the National Safety Council, however, thus putting North Carolina more on the spot than before.

We know that most accidents don't just happen—they are caused; consequently, they can be prevented. This being true, the medical and public health professions must marshal their forces in much the same manner that proved so successful against infectious diseases. Men like Dr. Julian Waller have the time and facilities to explore the problem in depth; it is up to the family doctor to implement the solutions.

In my opinion, despite all efforts, the situation is going to get worse before it gets better. Already Congress is being alerted to its responsibility, since this problem is not being solved by the states and counties. This means more federal control. Federal control is inevitable if the people themselves, in their communities, do not shoulder their responsibility to report the young reckless driver in the neighborhood, the elderly or ill driver in the family, the alcoholic who persists in driving, or the unlicensed driver. There are

about 40,000 of the latter yearly in North Carolina, most of whom have had their licenses revoked but who continue to drive. In other words, people must take the attitude that they *are* their brothers' keepers.⁹

This has traditionally been the attitude of the family physician. And I respectfully submit that the family doctor with this attitude has a key role in accident prevention. He is on the firing line and he is usually aware of most of the "accidents looking for a place to happen." All he needs is an awareness of the constantly changing nature of the complex problem and a high index of suspicion.

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The Role of the Family Doctor in the Social Problem of Child Abuse

Comments on New Legislation Affecting the Legal Immunity of Physicians

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SYLVA

This paper will present no new scientific data, no pictures of battered children, and no statistical analysis of cases. Rather, it will deal primarily with recent legislation designed to protect the abused child and the physician who treats him. Secondly it will comment on another new law that provides legal protection to physicians who stop to render aid at the scene of an accident.

In recent years a growing concern about the plight of the abused child has been evidenced by numerous articles in lay and professional journals telling how to recognize the problem and what to do about it. In most instances it has fallen within the province of welfare departments to investigate cases brought to their attention by the courts or by physicians and other concerned persons. In general this has been the pattern in North Carolina.

Read before the Section on General Practice of Medicine, Medical Society of the State of North Carolina, Asheville, May 3, 1966.

It has been demonstrated that only a small percentage of abused children are being reported and subsequently helped. With increasing urbanization and adherent weakening of neighborliness, abuse of children appears to be increasing. In small towns and rural areas, child abuse is at least observed and recognized even if little is done about it. In the city, however, a child and his problem are easily lost in the unconcerned crowd.

Physicians' Reluctance to Intervene

A recurrent theme in discussion of the subject is that the physician, who with his trained eye and sensitive ear is often the first to observe evidence of abuse and is the logical person to initiate appropriate action, has been consistently reluctant to report such cases to the proper authorities. We physicians have been a lot like Willie in this respect. Willie is the day laborer who shows up at the emergency room at 2 A.M. with a long, clean laceration of his arm. While sew-

ing him up you generally say irritably, "Who in the hell did this to you?" And Willie answers, "I don't know, Doc. Somebody jumped out in the dark and cut me. I don't know why." Or, "Didn't nobody cut me; I fell down the bank and fell on a piece of glass." Willie's problem is what the lawyers term "lexophobia"—an abiding fear and distrust of the law, and he will go to great lengths to avoid becoming involved. We suffer from the same fear to some degree, although for different reasons, and it has a great deal to do with our reluctance to become involved in cases of child abuse.

While welfare department and other agencies wondered at our unwillingness to report these cases, our attorney colleagues knew some of the primary reasons. They pointed out, to use the legal terminology, that a physician or one making a representation which he believes to be true but is found to be false, is liable in fraud if he did not use a reasonable degree of care in determining the truth or falsity of his allegations. This means, very simply, that in the past, before we could bring an allegation about a case of suspected abuse, our legal liability demanded that we make a fairly extensive investigation of our own. The attorneys also pointed out that disclosure of privileged information to a patient's detriment, or even for his benefit, can be ground for a suit.

Closely related is the confidential relationship that exists whenever trust and confidence are reposed in another under circumstances that impose on the person trusted the obligation to act in good faith. In addition, being constantly pressed for time and knowing that the wheels of the law grind slowly, we hesitate to get involved in problems that are basically social rather than medical.

These are some of the factors which have subconsciously kept our index of suspicion lower than it should be. As our former teachers used to repeat, almost *ad nauseam*, "You'll never see a case of pancreatitis (or whatever disease they happened to be discussing) if you don't think of it and look for it." Such is the background of the child abuse law.

Another reason for our past failure to act

in instances of child abuse has been a sense of futility and frustration—a feeling that even if we did make a report to the proper authorities, nothing constructive would come of it. In view of the new legislation and the growing willingness of the welfare and public health agencies to fulfill their responsibility, there is much less reason for us to feel this frustration. This coming year, for example, the State Department of Public Welfare anticipates setting up an abused child registry that will enable us to acquire experience with the various types of problems and to develop better mechanisms for handling them within the appropriate agencies.

We are realizing that there are more instances of child abuse and neglect than we have been aware of, and we can expect to hear more and more about the problem in our increasingly urban society. The general practitioner obviously stands in a unique position to recognize abuse, owing to his contact with families as units and his knowledge of their physical and social backgrounds as well as their medical problems. In our practice we all have families in which child abuse might be expected to occur or could occur. We have a unique opportunity to prevent such occurrences by increasing our index of suspicion and being more watchful for evidence of abuse.

In essence, of course, the general practitioner's role is that of case finding.

The Abused Child Law

During the Legislature of 1965 Senator Ruffin Bailey of Wake County introduced a bill dealing with child abuse. The original bill was quite broad in scope, and its enforceability was seriously questioned. The legislators were agreed as to its purpose, however, and finally approved a substitute bill introduced by Senator Herbert Hyde of Asheville. This bill, which is quite short, became a part of the North Carolina General Statutes. Regarding the immunity of physicians and others who report instances of abuse or neglect of children it reads as follows:

Any licensed physician or surgeon, any licensed nurse, or any school teacher, principal, superintendent, or other administrative head of a school, or

any employee of a county department of public welfare who in the pursuit of his profession or occupation shall make an observation or acquire information causing him to believe that a child under the age of 16 years suffers from any illness or has had any injury inflicted upon him as a result of abuse or neglect by a parent, step-parent, guardian, custodian or person standing in loco parentis to such child, or institution or an agent or employee of an institution having the authority of a parent or guardian over such child, may report to the county director of public welfare in the county where the child resides, the names and addresses of the child and his parents, or other persons responsible for his care, the age of the child, the nature and extent of the child's injury or illness, including any evidence of previous injury or illness, and any other information that the maker of the report shall believe might be helpful in establishing the cause of the injury or illness and the identity of the persons causing or responsible for the abuse, neglect, injury or illness. (General Statutes of North Carolina, Sec. 14-318.2)

The second paragraph of this law, which is of primary concern to physicians, states that "anyone who makes a report pursuant to this statute and anyone who testifies in any judicial proceeding resulting from the report shall be immune from any civil or criminal liability that might otherwise be incurred or imposed for so doing unless such person acted in bad faith or with malicious purpose." (General Statutes of North Carolina, Sect. 14-318.3)

The law also states that the director of public welfare shall attempt to determine who caused the abuse and "shall take such action in accordance with the law necessary to prevent the child from being subjected to further abuse, neglect, injury or illness." (General Statutes of North Carolina Sect. 8-53.01)

It is noteworthy that the permissive wording "may report" rather than "shall report" is used, contrary to similar laws enacted in many other states. In granting legal immunity to physicians and others, our legislators did not consider it necessary to impose new legal obligations. In many states the law requires that reports be made in writing, and to law enforcement agencies directly. The North Carolina law does not specify the manner of reporting, but does specify that the report be made to the department of

welfare. This would seem to be a wise provision, inasmuch as the welfare department has trained personnel who should be able to evaluate the problem within a much broader social framework than can either a physician or law enforcement officer.

It is the intent of the law that in investigating a case, the welfare department works with patients and helps bring about family situations and attitudes that will prevent recurrence of abuse without having to resort to legal action or to removal of the child from home. For example, when a report of gross malnutrition and neglect on the part of a small child leads to the discovery of a teenage bride and her teen-age husband, living in a cold water flat behind the railway station, good welfare practice would be to bring the best available services to bear on the problem. These might include advice from a nutritionist, help with job placement, and possibly temporary financial aid while the husband obtains vocational training. These measures could well prevent a recurrence of malnutrition and abuse, at least a part of which was the result of overwhelming circumstances rather than willful neglect.

The Neglected Child

Our concern should not stop with the obviously bruised and battered child whose drunken father has beaten him almost insensible. In such a case our basic humanity prompts us to action. We should be equally alert, however, to cases of malnutrition possibly due to neglect, and to correctable medical problems that are going untreated. We might well concern ourselves with the unprotected rheumatic child, for example. There have been times when we were unable to convince a family of the importance of continuing penicillin prophylaxis, or of getting a necessary tonsillectomy and adenoidectomy performed on a child. If our teaching is reinforced by public health nurses and welfare workers, we may be able to accomplish much more. These are all forms of child abuse, although not of the sort that usually requires legal action. More commonly such cases call for welfare and public health assistance.

The "Good Samaritan" Law

Legislators with whom I have discussed the child abuse law asked me to use this opportunity also to bring to your attention the so-called "Good Samaritan" Law, which was also designed for the protection of physicians. Much has been said about the unwillingness of physicians to stop and render aid at the scene of automobile accidents, presumably because of the fear of being held liable for the outcome. It appears that this problem has been greatly exaggerated. The legal department of the American Medical Association reports that there are no known instances of successful suits against physicians who attempted to help victims of accidents. Many doctors fear, however, that they may be held liable, and for this reason avoid involvement whenever possible.

I suspect that much of this reluctance can be traced to medical specialists who hesitate to stop at the scene of an accident because their special training and experience do not encompass the problems they are likely to meet. I suspect that many are afraid that they wouldn't know what to do if they did stop. This problem obviously doesn't apply to general practitioners. We have a much broader base of experience which equips us to deal with almost any emergency we are likely to meet at an accident scene. At least we should be more competent than the willing layman who stops to help. One of the legislators who helped pass the Good Samaritan law said they had been told that medical students were being taught by their professor to pass by accidents in order to avoid legal liability.

The 1965 law (North Carolina General Statutes, Sect. 90.1-21.1-21.4) was specifically designed to remedy this situation, which has served to restrain physicians from rendering services at accident scenes. It states that "any person who renders assistance at the scene of a motor vehicle accident on any street or highway, to any person injured as a

result of such an accident, shall not be liable in civil damages for any acts or omissions relating to such services rendered, unless such acts or omissions amount to wanton conduct or intentional wrong doing."

It is true, of course, that what amounts to "wanton conduct" on the part of a trained person differs from what constitutes wanton conduct on the part of a layman. However, this law does effectively prevent legal reprisals against the physician who stops in good faith and offers medical aid to accident victims. What the law actually accomplishes, I think, is to relieve our minds of what has probably been an exaggerated fear of legal reprisals.

Summary

The purposes and implications of two laws enacted by the North Carolina General Assembly of 1965 are discussed.

The so-called abused child and good samaritan laws were enacted primarily to remove from the minds of physicians and other concerned persons the fear of incurring legal reprisals, which heretofore has constituted a barrier to the reporting of instances of abuse, and to set up a mechanism for investigating suspected cases. The law puts the responsibility for making such investigations squarely on the Department of Welfare, and removes from physicians the responsibility of taking legal action in real or suspected cases. The responsibilities of the physician toward the abused child are emphasized, and the scope of the problem is broadened to include not just the battered child but also the malnourished or sick child who is not receiving the treatment he is entitled to and should have.

The so-called Good Samaritan Law likewise grants legal immunity to the physician who stops in good faith to offer medical aid to victims of accidents.

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CAN WE IMPROVE OUR INFANT MORTALITY RATES?

For reasons that are primarily socioeconomic, the infant mortality rate in this country is decidedly lower for the white race than for other races. The inverse relationship between socioeconomic status and perinatal mortality has been demonstrated in many studies. The large number of nonwhite births that occur at home and are unattended by a physician is one of the factors responsible for the higher perinatal mortality

among nonwhite races. Fortunately, conditions in this state have gradually improved to the point that only 17.5% of nonwhite births now occur outside a hospital; the incidence of home deliveries among the white race is insignificant (0.4%). Another factor responsible for higher perinatal mortality in nonwhite races is the large proportion of illegitimate births (26.8%, as compared to 2.6% in the white race).

Vital statistics have long been used as a source of clues to remediable causes of death. It is extremely unfortunate, therefore, that information given on birth and death certificates is often neither reliable nor complete. Greater accuracy in completing certificates of birth and death might bring to light many factors that would be of significance in planning approaches to the problem of mortality among both white and nonwhite infants. In the five year period 1959 through 1963, the "ill-defined and unknown" category ranked fourth among causes of postnatal deaths in this state, accounting for some 12% of the total. Mechanical suffocation is frequently given as the cause of deaths in young infants, although most pathologists would agree that such cases are rare and that in most infants who appear to be the victims of suffocation the actual cause of death is an acute disease. Careful attention to the history of the illness would often reveal the true cause of death in such cases.

Although a great deal might be gained by the performance of more and better autopsies, the problem of obtaining autopsies that are adequate both in number and in quality has not been solved. Furthermore, even with careful autopsies, it is frequently difficult to determine the true cause of deaths occurring in patients who are not under a doctor's care. Only 58.1% of nonwhite infants and 74.9% of white infants expiring in the postneonatal period were receiving medical attention at the time of death.

Two articles appearing in this issue suggest that significant and accurate information made available through vital statistics records would be of tremendous value in studies aimed at reducing infant mortality rates. It is to be hoped that the new classification of illness now being prepared by the

World Health Organization will make possible more accurate coding of the causes of death, and that revisions of the death certificate may eliminate some of the problems that now exist.

The maternal mortality study conducted for the past several years by the Medical Society of the State of North Carolina has clearly demonstrated that significant improvements can result from an intensive investigation of the causes of death. There is reason to believe that such a detailed study of the factors associated with deaths in the postnatal period would be equally rewarding.

THEODORE D. SCURLETIS, M.D.

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MOTORCYCLES

A recent article in the *JAMA*¹ reports a number of cases of injury and death following motorcycle accidents, calling attention to this popular form of trauma. The growth of motorcycling should give pause to anyone so foolish as to think rationality plays much part in human conduct.

The motorcycle is, in a sense, a throw-back in this country. Wheeled transportation usually reflects economic progress. When a man abandons shank's mare it is usually for a bicycle initially, a step taken in this country in childhood and in others only when as an adult a bicycle can be afforded. From the bicycle one may go directly to the automobile in affluent circles, in less affluent to a motorbike, motorscooter or motorcycle, thence to a small car, and if and when tycoonery arrives, a large car.

This orderly and reasonable progression, conditioned by money, has been shortcircuited by the influence of sporting blood, aided by insidious flackery which equates motorcycle riding with a pretty blond clutching one from the dorsum. No mention is made of the gradually sliding kidneys, loosening teeth, motes in the eye, shattered skulls, broken arms, or the final triumph of modern advertising, the expensive premature funeral.

In fairness to the motorcyclist, not all the notable mortality and morbidity is his or her fault. The carelessness of automobilists, cutting the unarmored rider off and

leaving him to his fate, is a major factor in these accidents. However, accidents they are, and putting the blame on the auto is little solace to them or their survivors.

Reference

1. Dillihunt, R. C., Maltby, G. L., and Drake, E. H.: The Increasing Problem of Motorcycle Accidents, *JAMA* 196: 1045-1047 (June 20) 1966.

* * *

THE DEPARTMENT OF WELFARE MODIFIES DRUG PROGRAM

Practicing physicians will be interested in the announced revision of the rules of the State Department of Welfare as they apply to its program for recipients of public assistance to remove the limitation of ten dollars (\$10.00) on single prescriptions written by physicians for patients in the public assistance categories. This should be recognized as an effort toward better medical practice and deserves the full cooperation of the profession. The elimination of this restriction will relieve the physician treating patients requiring long term medication of the recurring necessity for multiple prescriptions, and should result in time saving for both the physician and the pharmacist.

It is of interest that in the first six months of 1966 the number of prescriptions filled and their cost almost equalled the total for the entire year 1965, indicating the expanding cost of the program. The new rule should represent an economy dependent upon a sense of responsibility on the part of physicians to limit drug quantity to the anticipated needs of the patient.

The Medical Society, through the JOURNAL, brings this matter to the attention of physicians in practice with the full appreciation of the State Welfare Department and its confidence in the good judgment of the profession.

J.S.R.

* * *

ESPRIT DE CORPS AND THE TURNER'S LANE HOSPITAL

When one speaks of *esprit de corps* one calls to mind some force which makes the whole greater than the sum of the parts in the case of a human assemblage. An ac-

count of such spirit in U. S. medicine is contained in an article on Turner's Lane Hospital in Philadelphia appearing in the *Bulletin of the History of Medicine* (40:14-42, Jan-Feb. 1966). In it, Dr. William S. Middleton describes the activities of Drs. S. Weir Mitchell, W. W. Keen, and G. R. Morehouse in the study of peripheral nerve injuries at that little facility during the Civil War. Our readers will be amused by a quotation in the introduction from Mrs. Alice Westerley: "I wish, for my part, we could tow Massachusetts and South Carolina out to sea, and anchor them together and let them settle their difficulties." They will also be absorbed in the account of the exhilarated period of activity on the part of these men which so advanced the profession's knowledge of nerve injuries, hitherto handicapped by incomplete anatomic knowledge and inadequate support of methodical attempts to study them. One also remembers that more than 20 years later when President Garfield was shot, his attendants apparently paid little attention to his signs and symptoms of peripheral nerve injury, and did not make interpretations which would have spared him much pain and perhaps his life.

At Turner's Lane the Surgeon-General of Army, Dr. William A. Hammond, authorized the establishment of a hospital for nerve injuries and disorders, entrusting it to Mitchell, then 33 years old, and Morehouse, the same age. W. W. Keen, younger than the others by 8 years, joined them later. While Keen lived at the hospital Mitchell and Morehouse continued their Philadelphia practices, but spent much of the rest of their waking hours at Turner's Lane working long into the night. Out of their efforts came two classic treatises, "Gunshot Wounds and Other Injuries of Nerves" in 1864, and "Injuries of Nerves and Their Consequences" in 1872, and many other publications on such subjects as malingering, and the antagonistic effects of morphine and atropine. Their treatment of causalgia remains a useful account to the present time. In writing on the phantom limb phenomenon, Mitchell even included the public, publishing an account in Lippincott's Magazine.

Reading Dr. Middleton's paper, and knowing that he was once responsible for the medical activities of the Veterans Administration, one cannot but wonder if he was not assessing the gain in knowledge per dollar spent at Turner's Lane and in modern hospitals. Such a comparison is not valid, of course, for in the last analysis it is people, not facilities, that mark a given period of time as productive or routine. The account of what Mitchell, Morehouse and Keen did is an inspiration and well worth the short time it takes to read it.

* * *

WHAT'S IN A HYPHEN? OR A NAME?

Henry Bence Jones, dead these 93 years, is not around to defend himself against those who would put a hyphen between his middle and last names, the latest such indignity coming into view at the hands of his countrymen, in the April, 1966, issue of "Biochemical Journal." Perhaps one of the hazards of inheriting Jones or some other common name is that someone will want to tack another name on with a hyphen to make it distinctive, as in the case of Anthony Armstrong-Jones (who has achieved distinction in other ways as well). This thought is more appealing than a Freudian interpretation, which in any case is not within our tastes or ability.

There is some solace, of sorts, for those with common names. We will soon be known only by number to those vast forces which watch over us as we labor in the hive. Perhaps at birth we will have a number tattooed in our armpit, thereby sparing all we meet along life's path, and after we are dead and awaiting autopsy, of worrying about who we are. Going further, when this step is accepted, the number may move from armpit to forehead (or malar prominences if hair continues to proliferate on head and face), eliminating badges at meetings and covert glances at the jacket front. Withal, one doubts that mothers will ever take up the numerology approach, or that nicknames have much of a future. Henry Bence Jones, despite the intrusive hyphen, may end up with the more acceptable designation.

The President's Page

MEDICAL-HOSPITAL-COMMUNICATIONS MEDIA RELATIONS

This subject has in the past been called 'Press Relations'. There is also a terminology frequently used, 'Hospital Press Relations, or, as was the title of a recent presentation, 'Good Hospital Press Relations.'

Let us look for one moment at this implication of 'Good Hospital Press Relations.' It would seem that without a hyphen, or the word 'and' between 'Hospital' and 'Press,' we are running on a one-way street. Such implies that it is proper that the hospital have good relations with the hospital. Of course, the ideal is a two-way street.

As we have moved along in our culture, other means of public communication of news and related subjects have developed. First, there was radio, and then television. These modalities express the audio-visual components of the special senses common to man. What special sense is next in the public communications area? Olfactory? Tactile? Far afield? No! Give man an idea, an opening for the utilization of an idea, and a profit motive, and that idea is implemented. 'Smellies' with olfactory stimuli for mood construction and sensation impact? 'Solidos' for three dimensional tactile sensation? Could be! This is in the future, but possible. Here we deal with today only and the known tomorrow.

Williams James said, "We may philosophize well or ill, but philosophize we must." In the brief prologue which follows, an attempt will be made to discuss some of the philosophical variances which exist between the people of the news media and those who are medically oriented. This discussion is not intended as a guide or a code, but merely as a vehicle for the dissemination of general information in this area of Medical-Hospital-Public Communications Relations.

The Press

Article One of the Amendments to the Constitution of the United States says as follows: "Congress shall make no law respecting an establishment of religion or prohibiting the free exercise thereof, or abridg-

ing the freedom of speech, or of the press, or the right of the people to peaceably assemble, and to petition the Government for a redress of grievances."

This is one of the Articles of the ten commonly known as the Bill of Rights. These ten Amendments, including the one which came to be known as Article One, were ratified by all the states then existing and were in force from December 15, 1791. 'Freedom of the Press'! Charles and Mary Beard, in their *Basic History of the United States*, say: "Newspapers for the distribution of knowledge and ideas, true or false, multiplied in the republican era and forty-three newspapers, it was estimated, lived through the Revolution." It was then from these few that the mighty news media of our land have sprung.

The 'Canons of Journalism' of the American Society of Newspaper Editors in its Preamble states: "The primary function of newspapers is to communicate to the human race what its members do, feel, and think . . ." In these 'Canons', principles are laid down regarding sincerity, truth, accuracy, and good faith. Impartiality is discussed in Article V and herein is stated: "News reports should be free from opinion or bias of any kind."

Radio-TV

In 'Standards of Practice' of the Radio-TV News Directors Association, Section Four, it is stated in the first sentence, "Presentation of the news must be accurate, factual, and in good taste." In Section Six, the wording is "commentary and analysis must be clearly labeled as opinion and comment."

Hospitals

In 'Code of Ethics' of the American College of Hospital Administrators and the American Hospital Association, there is a paragraph following the ten principles of hospital ethics discussing relationships of hospitals with agencies of information as follows: "Fully recognizing that the press, radio, and other communications media are

excellent vehicles of public education and have a responsibility to disseminate information to the community, the hospital must appreciate its moral obligation to the patient and to the professional groups represented in its organization. Consequently, information about patients, except as required by law and/or where privileged communication is involved, should not be given without the consent of the patient or the patient's immediate family, and the patient's physician."

Medicine

In 'Principles of Medical Ethics' of the American Medical Association, Section Nine states: "A physician may not reveal the confidence entrusted to him in the course of medical attendance, or the deficiencies he may observe in the character of the patient, unless he be required to do so by law, or unless it becomes necessary in order to protect the welfare of an individual, or of the community."

In 1803, Thomas Percival, philosopher-writer and a physician of Manchester, England, conceived a "Scheme of professional conduct relative to hospitals and other charities." It was from this Scheme that he derived the code which is known as Percival's Code of Medical Ethics. In 1847, at the first really organized meeting of the American Medical Association, in Philadelphia, a code of ethics was established. It is apparent from the record that this was based upon Percival. From those reasonably recent events, our present Principles of Ethics has been derived.

Hippocrates and the Ancients

Twenty-two centuries prior to the ratification of Article One of the Amendments to the Constitution of the States of the New America, and the compilation of Percival's Code, another set of precepts was laid down. Hippocrates, in his swearing by Apollo, physician, by Aesculapius, by Health and by Panacea, eventually said, "In whatsoever houses I enter, I will enter to help the sick, and I will abstain from all professional wrong-doing and harm, and whatsoever I see or hear in the course of my profession or in my intercourse with men, it shall not

be published abroad, I will never divulge, holding such things to be holy secrets."

Twenty centuries before Hippocrates, as we measure recorded time, the great Code of Hammurabi was developed. Even this was based on handed down law from the Sumerian civilization which preceded by centuries the era of the Babylonians and Hammurabi himself. This Code set forth many ethical principles for physicians, among which was a reference to bearers of tales and punishment therefor. Information is not available as to the punishment for revelation of personal secrets divulged by the patient in presumed confidence while undergoing professional ministrations, but we do know that what came to be later known as 'lex talionis' often applied. For instance, the unskillful surgeon's mistakes might cost him the loss of his hand or heavy fines. Hammurabi's Code was a code of all laws, not just those relating to medicine.

Five thousand years is not long as measured in the ages of sentient life on this planet; yet, for recorded history, it is long. So then physicians have long been restricted by ethic and by law as to what they may reveal.

The Modern Law

The use of the words 'privileged communication' brings into play a further consideration to this discourse—The Position of the Law.

North Carolina General Statute 8-59 states:

"No person, duly authorized to practice physic or surgery, shall be required to disclose any information which he might have acquired in attending a patient in a professional character and which information was necessary to enable him to prescribe as a physician, or to do any act for him as a surgeon: Provided that the Presiding Judge of a Superior Court may compel such disclosure if, in his opinion, the same is necessary to a proper administration of justice."

Yow versus Pittmen, 241 N. C. (1954), using this Statute as a base, and because of it states: "The law protects the patient's secrets and makes it the duty of the doctor to keep them, a duty which he cannot waive." A DUTY WHICH HE CANNOT WAIVE.

This Statute is referred to as a 'qualified privilege' statute because there is no common law 'confidential communication privilege'. It is qualified in that a Judge of a Superior Court can waive it. This privilege of communication rests solely with the patient and not with the physician or with the hospital.

Ligon, in his excellent compendium, *North Carolina Hospital Law*, says:

"Civil liability could attach to a physician or a hospital or its individual employees if the information contained in the patient's records were indiscriminately released to third persons without the consent of the patient."

He goes on to say:

"The right of the individual to be spared certain unasked for and unnecessary publication of his private affairs is well recognized. . . . Since the right to be left alone is an interest that has gained recognition only in recent years, the law providing for its protection has not crystallized completely, although it has been recognized in North Carolina."

We have now encountered a stumbling block in this matter of communications media — hospital-physician relationship — because the right of the individual patient must be balanced against the right of the people to be informed in matters of the public interest. One could go far afield in any dialogue over the divergent philosophical tenets involved in the contending which pits the invasion of privacy, on the one side, and the right of the populace to be informed on the other. At which point does the sword of Damocles fall upon the possessor of information which might be construed to be privileged?

Certainly, those items or situations which are a matter of public record and are by law to be reportable to public authority are not privileged. Communications media are entitled to have accurate and prompt information as to the matters involved. Since these matters are of public records and are often listed upon the police reports, such data as name, marital status, sex, presumed age, occupation, possibly color, address, and the name of next of kin could be released by a

spokesman for the hospital without consent of the attending physician. For instance, the condition of a patient in a general way may be divulged—good, fair, serious, critical, etc. A very brief statement as to the manner in which the accident allegedly occurred without any details, and a brief guarded disclosure of the extent of injuries couched in lay terms, would seem to be in the public interest. Great care must be exercised in the matter of premature disclosure of the death of any individual prior to making a satisfactory and reasonable attempt to contact the family or the next of kin.

Wherein a situation involves cases that are not a matter of public record, the physician or hospital may release information only **WITH THE PATIENT'S EXPRESSED PERMISSION**. Immediately one runs into the question of certain releases regarding public officials and or persons of significant prominence to cause them to be possibly within the public domain more so than other individuals. Herein the question of prognosis enters the picture. The state of health or unhealth of these people may be of vital concern to many, way and above the consideration of curiosity. Does an individual who has attained prominence by virtue of such attainment forswear his or her right to object to the invasion of privacy? Where do individual rights begin? Where do they stop?

In this changing world, in this era of kaleidoscopic and unsettled ideological conflicts, in this century of the stupendous plunge into tomorrow when yesterday has not yet been fully digested, must we consider that we are born in, that we are to be sick in, and that we are to die in glass hospitals?

Nothing so far has been said with reference to 'a physician in the news', as far as scientific news, the individual physician, and the County Medical Society. Rather than burden this account with detail in this connection, it is better that a reference be made to a very excellent "Guide For Physicians, Hospitals, and News Media," a joint service publication of the State Medical Society of Wisconsin, the Hospital Association of Wisconsin, and the Newspaper, Radio, and Television Association of Wisconsin. This booklet goes into considerable detail in these areas.

Section 10, of the "Principles of Medical Ethics" is elaborated upon in detail in this connection in a booklet, "Opinions and Reports of the Judicial Council" of the American Medical Association, 1964. This portion refers to the relationship of the physician to the media of public information; advertising and the daily press; release of medical information to the press; and the use of physicians' names in connection with civic enterprises, among other related items.

In October of 1963, a pocket sized publication of eight pages was developed and approved by the North Carolina Press Association, North Carolina Association of Broadcasters, The Medical Society of the State of North Carolina, and the North Carolina Hospital Association. This is titled NEWS MEDIA GUIDE and was prepared for printing by the North Carolina Hospital Association.

To further brief guide, the following is offered:

Cases of Public Record

What are they?

- A. Persons under arrest or held under police surveillance.
- B. Persons brought to the hospital by the Fire Department or any law enforcement agency.
- C. Shootings, stabbings, poisonings, injury by automobile and animal bites, and any other case reportable to civil authorities.

What identification is proper?

Name, address, sex, race (this may or may not be applicable today), age, marital status, occupation.

Condition of patient:

Good, fair, serious, critical—that's all.

Nature of accident:

Type of accident, no details. Very brief statement of extent of injuries. Lay off self-infliction, intoxication, and refer to the police the specific questions regarding shootings, stabbings, and sexual assault.

Type of injury:

Unconsciousness. If unconscious when brought to the hospital, one may so say. One may state that there are fractures of a given member, and that is all. One may say that there are head injuries, internal injuries, or burns, and that is all.

General:

If a baby was born, one can so say, since such is public information. If a person dies, this may be revealed after the next of kin has been notified, or a reasonable attempt has been made to do so. Again, this is public information.

Omit statements regarding intoxication or sexual assault.

There are other areas of interest in this brief guide, and it may be consulted for detail.

This presentation is not made as an authoritative reference, but rather with the idea in view of acquainting the involved disciplines of certain philosophical attitudes, some history, and possibly sources of material for more detailed study.

Given before the North Carolina Conference on Nursing and Patient Care, Quail Roost Conference Center, Rougemont, North Carolina.

FRANK W. JONES, M.D.

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Bulletin Board

COMING MEETINGS

Ninth District Medical Program on Cardiopulmonary Resuscitation—The Moose Club, Hickory, September 9.

North and South Carolina Societies of Ophthalmology and Otolaryngology, Joint Meeting—Sheraton Motor Inn, Winston-Salem, September 11-13.

North Carolina Association for Retarded Children—Jacksonville, September 16-17.

Charlotte Postgraduate Seminar—Presbyterian Hospital, Charlotte, September 21-22.

Forsyth County Heart Symposium—Winston-Salem, September 30.

Fifth District Medical Society Meeting—The Country Club of North Carolina, Pinehurst, October 5.

University of North Carolina School of Medicine, Conference on "Grief and Depression—Their Crisis and Management"—Chapel Hill, October 6-8.

The Herman Cone Lecture—Moses H. Cone Memorial Hospital—Greensboro Public Library, Greensboro, October 20.

North Carolina Academy of General Practice, 1966 Scientific Assembly—Hotel Jack Tar, Durham, October 27-28.

North Carolina Society for Crippled Children and Adults, Annual Convention—Mid Pines Hotel, October 28-29.

Society of Nuclear Medicine, Southeastern Chapter—Jack Tar Hotel, Durham, November 3-5.

Southern Thoracic Surgery Association, 13th Annual Meeting—Grove Park Inn, Asheville, November 3-5.

North Carolina Pediatric Society—Mid Pines Club & Golfotel, Southern Pines, November 4-5.

NEW MEMBERS OF THE STATE SOCIETY

Drs. Charles E. Wiley, GP, Box 307, Banner Elk; James Edward Etheridge, N, Willow Terrace, Apt. 62, Chapel Hill; Joanna Stein Dalldorf, Pd, 11 Woodhaven Road, Chapel Hill; William Seymour Pearson, P, 1035 Chester Road, NW, Winston-Salem.

NORTH CAROLINA STATE RURAL HEALTH CONFERENCE

The following tentative program has been arranged for the one-day statewide Rural Health Conference scheduled for Thursday, Sept. 15, at the Sir Walter Hotel, Raleigh.

Morning Session

10:00 Presiding—W. Wyan Washburn, M.D., Past-Chairman, AMA Council on Rural Health, Boiling Springs

Invocation—Rev. T. J. Youngblood, Jr., Raleigh

10:15 Health Needs Today—Frank W. Jones, M.D., President, Medical Society of the State of North Carolina, Newton

10:45 Problems in the Shifts of Populations from Rural to Urban and Urban to Rural Areas (speaker to be announced)

11:15 Impact of the Regional Health Centers on Rural Medicine

George W. Paschal, Jr., M.D., Raleigh, Moderator

Robert H. Shakelford, M.D., Mt. Olive

E. Harvey Estes, Jr., M.D., Durham

Ladd W. Hamrick, Jr., M.D., Concord

12:15-2:00 P.M. Unscheduled Lunch Period

Afternoon

2:00 Immunizations (speakers to be announced)

2:30 An Example of a Successful Mass Immunization Project—Henry B. Woodard, N. C. State Board of Health, Raleigh

2:40 Panel on Family Safety Practices

Home Safety—Hugh A. Matthews, M.D., Moderator

Farm Machinery Safety—Frank K. Allen, Farmville

Traffic Safety—Col. Charles A. Speed, Raleigh

Pond and Water Safety—George E. Burdick, Colerain

3:30 Solving Our Health Needs Today—Robert A. Ross, M.D., President-Elect, Medical Society of the State of North Carolina, Chapel Hill

4:00 Recognition of 4-H Health King and Queen families

4:05 Adjourn

Announcement of the program was made by Dr. Edward L. Boyette, chairman of the Committee on Community Health (Rural and Urban), Medical Society of the State of North Carolina.

NEWS NOTES FROM THE DUKE UNIVERSITY MEDICAL CENTER

The Ford Foundation, in what it termed a major effort to advance the quality of higher education in the South, recently announced grants totaling \$33.5 million to Southern institutions, including an \$8,000,000 gift to Duke University.

Awarded under the Foundation's Special Program in Education, the grant to Duke must be matched at a ratio of four-to-one over the next three years. It is the largest single gift made to Duke since 1924 when James B. Duke provided the endowment which enabled Trinity College to become Duke University.

The grant comes at a time when Duke has undertaken a three-year campaign for \$102.8 million—the largest fund raising effort ever launched by a Southern university, and one of the largest in the Nation.

The grants provide matching funds that selected private universities and colleges may use for whatever purposes will enhance their academic programs, such as faculty salaries, fellowships, curriculum development and buildings.

* * *

The Department of Psychiatry at Duke University Medical Center is developing a training program in Geriatric Psychiatry. The scope of the two-year program includes training in psychosocial gerontology,

geropsychiatry, geriatrics, psychologic, and biologic gerontology. These areas, the core curriculum for the first year, are covered in weekly seminars with assigned reading, visiting lecturers, and case presentations. Clinical training includes case studies and supervised therapy of elderly patients in a geropsychiatric outpatient clinic and inpatient service; geriatric patients on the neurological, medical and surgical, and psychosomatic services; and a day care unit as well as a state hospital and a retirement home. Liaison with the North Carolina Mental Health Department will provide further training in social gerontology and community geropsychiatry. Research training in the field of aging includes supervised research in clinical settings. Flexibility will be maintained to adapt the training program to the specific career plans of individual trainees.

The members of the Geriatric Psychiatry Training Committee, represent the five basic content areas of the training program. In addition, many qualified faculty members are available for training and supervision in theory, treatment, clinical and basic research in the field of aging. A personal adviser helps the trainee in formulating specific career plans which are then implemented with assistance of an advisory committee. The latter is composed of faculty members whose spectrum of interests falls in line with that of the trainee.

Key professional training personnel are Adriaan Verwoerd, M.D., program director; Ewald W. Busse, M.D., chairman, Department of Psychiatry; director of the Center for Study of Aging; George L. Maddox, Jr., Ph.D., professor of sociology and medical sociology; Walter D. Obrist, Ph.D., professor of medical psychology; Larry W. Thompson, Ph.D., assistant professor of medical psychology.

The Geropsychiatry Training Program will cover a period of two years. Occasionally, trainees who desire training in specific skills can be accepted for one year. Preference is given to applicants with three years of residency training in psychiatry. However, applicants who have two years of training will be considered. In the latter case arrangements for satisfactory completion of basic residency training requirements will be made in accordance with individual needs.

There are no age requirements. Citizens and non-citizens with visas for permanent residence are eligible.

For further information write to: Adriaan Verwoerd, M.D., Program Director, Geropsychiatry Training Program, Duke University Medical Center, Durham, N. C.

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A regional diagnostic and treatment laboratory for victims of a cancer peculiar to pregnant women—trophoblastic neoplasms—is to be established at Duke University Medical Center.

The new center will be financed by a federal grant of \$35,738. The award is the first of three that will total about \$75,000.

The grant, made to Dr. Roy T. Parker, professor and chairman of the Department of Obstetrics and Gynecology, will enable Duke physicians to make early diagnosis of the tumor through measurement of a hor-

mone called chorionic gonadotrophin which is produced by the tumor and found in the urine.

The laboratory will provide community physicians throughout the southeastern part of the United States with rapid, accurate tests of gonadotrophin excretion in patients suspected or found to have the tumor.

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The National Institute of Neurological Diseases and Blindness has announced a grant of \$43,848 to establish a training program in ophthalmology at Duke University Medical Center.

The award will provide stipends for nine residents in ophthalmology who will undertake research projects in addition to doing clinical work.

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A four-year clinical training program on the diagnosis and treatment of cancer at Duke University Medical Center has been approved by the National Cancer Institute which recently announced a first-year grant of \$107,055 for the project.

The project is intended to improve the training of medical students, interns, residents, and practicing physicians in the basic concepts and clinical management of the disease.

Named as principal investigator of the project was Dr. William W. Shingleton, professor of surgery and chief of the division of general surgery.

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Dr. Frank G. Hall, former chairman of Duke University Medical Center's department of physiology and pharmacology, has been elected a fellow in aerospace medicine for his work in that field during and after World War II.

Dr. Hall has been emeritus professor since his retirement last August. His election to a fellowship in aerospace medicine came at the annual meeting of the Aerospace Medical Association in Las Vegas, Nev.

An authority on high-altitude breathing, he began his work in this field as a research fellow at Cambridge University in 1933.

Dr. Hall left Durham several weeks ago on the first of two scientific expeditions he will participate in this summer. He will join other researchers in a National Science Foundation study of the effects on man of the physical environment of the below-sea-level Mojave Desert and then carry out a similar study on 14,000-foot Mt. Barcroft with scientists from the universities of Indiana and Nevada.

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The success of a similar program three years ago has resulted in a new National Institutes of Health (NIH) grant to Duke University Medical Center for the training of clinical investigators in surgery.

The \$64,970 award for the first year of a seven-year program has been made to Dr. David C. Sabiston, Jr., professor and chairman of the department of surgery.

The award will enable the financing of expansion of a current program for the selection and training of outstanding surgical residents.

* * *

Duke University Medical Center is one of six medical

centers in the United States selected to conduct a pilot cooperative study of the results of surgery in congenital and acquired heart disease.

The work will be done under the direction of Dr. David C. Sabiston, Jr., professor and chairman of the Department of Surgery, with a two-year \$150,000 grant from the National Institutes of Health.

Specifically, the study is intended to provide pre-operative physiologic data that will enable physicians to diagnose with greater accuracy the exact physical condition of the heart and to determine whether a patient is a candidate for surgery.

* * *

Athos Ottolenghi, an associate professor of pharmacology at Duke University Medical Center, attended the third international conference on radiation research in Cortina, Italy, June 25-July 2.

While in Europe, Dr. Ottolenghi also visited the departments of hematology at the universities of Pavia and Parma, the Cutolo Research Institute in Naples, and the Laboratory of Organic Chemistry at the University of Utrecht, Holland.

* * *

Robin Blake, 21, a rising senior at Duke University who is planning a career in medicine, was the only non-physician to present a scientific paper at a session of the American Medical Association's annual convention held in Chicago last month.

He described to an audience of about 100 physicians the work he has been doing with an experimental drug with the jaw-breaking name of dichloroisoproterenol (DCI).

A chemistry major, Blake did the research with the cooperation of two physicians, Dr. Mark Dillon, an associate professor of surgery, and Dr. Saul Boyarsky, a professor of urology. The composition of the paper was entirely his own work.

* * *

Duke Hospital patients who are able to take care of themselves with supervision but do not need continual observation will be able to live in a new hotel here as of next month while getting needed medical treatment.

An arrangement between Duke Hospital and the new Statler Hilton Inn on Erwin road will make it possible for some patients to receive needed medical treatment outside the hospital at a saving of almost 50% in hospital costs.

The hospital is leasing a block of 26 rooms from the

hotel. Daily private room rates in the new self-care unit will be \$13.50 and \$14.50. Semi-private room rates will be \$10.50 a day.

Only those patients considered by attending physicians capable of participating in their own therapy will be able to take advantage of Duke Hospital's new unit.

NEWS NOTES FROM THE UNIVERSITY OF NORTH CAROLINA SCHOOL OF MEDICINE

Dr. Hugh M. Shingleton, obstetrician-gynecologist at the University of North Carolina School of Medicine and N. C. Memorial Hospital in Chapel Hill departed in late June for New York City and a year of basic research related to female cancer.

He has been awarded a Special Postdoctoral Fellowship by the National Cancer Institute to work in the departments of obstetrics-gynecology and pathology at Sloane Hospital for Women, a unit of Columbia-Presbyterian Hospital in New York City. His primary research interest is female genital cancer.

Dr. Shingleton is an assistant professor of obstetrics and gynecology and has been director of the gynecological tumor registry at the hospital in Chapel Hill.

* * *

Dr. Irving I. Gottesman, associate professor of psychology in the departments of psychiatry and psychology, has been appointed coordinator of research and training in behavioral genetics at the University of Minnesota in Minneapolis, effective October 1.

He joined the UNC faculty in 1963 and spent his first year on leave at Maudsley Hospital in London as a special fellow in psychiatric genetics, sponsored by the National Institutes of Health.

He has conducted research at UNC on the genetics of mental illness and human personality traits, using twins and their families as subjects.

* * *

Dr. Hans Strupp, professor of psychology in the departments of psychiatry and psychology, has been appointed professor of psychology at Vanderbilt University in Nashville, Tenn., effective with the fall semester.

Dr. Strupp now is president of the Section on Psychotherapy, Division of Clinical Psychology, American Psychological Association.



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BRYSON CITY, NORTH CAROLINA

Dr. Thomas B. Barnett, professor of medicine and head of the Division of Pulmonary Diseases, will leave on August 1 for a year of study and research at the University of Copenhagen in Denmark.

He plans to continue the respiratory physiology studies he is conducting in Chapel Hill. His major interests are in the effects of increased muscular activity on breathing, especially when the effects of muscular effort are devoted to the process of breathing, such as in emphysema and obstructive bronchitis.

Dr. Barnett will work in the physiology laboratories of Dr. Erling Asmussen at the University of Copenhagen. Dr. Asmussen and a co-worker, Dr. Marius Nielsen, are among the world's foremost scientists interested in the relationship between breathing and physical effort.

The year of study and research in Denmark will be supported by a National Institutes of Health Special Fellowship, supplemented by funds from the Commonwealth Fund of New York City.

* * *

Research grants totaling \$194,000 have been awarded to five scientists at the University of North Carolina by National Science Foundation.

Dr. Joseph S. Pagano, assistant professor of medicine, bacteriology and immunology in the School of Medicine, received \$56,000 for research on the infections of poliovirus.

He is attempting to detect how the nucleic acid core of the virus infects the normal cell and how it begins to replicate new viruses.

A "skin window" on a patient's forearm holds great promise of making it easier for physicians to understand the differences between tuberculosis and sarcoidosis (a disease which mimics TB).

The skin window technique has been used for about 20 years but its precise use at the Medical School is different.

Dr. Joseph C. Hathaway, Jr., UNC pathologist with a major research interest in diseases of the blood, is applying skin windows to the study of "local skin inflammatory patterns in tuberculosis and sarcoidosis."

The study is financed by a \$2,000 grant from the United States Medical Research Foundation of North Carolina.

* * *

Dr. William F. Eastman, marriage counselor with the Children's Aid and Family Service Society of Baltimore, Maryland, for the last three years, will join the Department of Psychiatry on July 1 as assistant professor of marriage counseling.

For the first time, medical students and physicians in advanced training will receive systematic instruction in the techniques of marriage counseling applicable to general medical practice.

Dr. Eastman will spend half of his time in teaching and research in the Department of Psychiatry and the other half with the psychiatric clinic of the UNC Student Health Service.

Dr. Edward L. Hogan, an assistant in neurology at Harvard Medical School for the past year, will join the

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Medical School faculty on July 1 as an assistant professor of neurology.

He completed his undergraduate work, was awarded his medical degree, and served as a Research Fellow in neurology and biochemistry at Tufts University School of Medicine.

* * *

Too many severely burned patients die because they "just run out of gas—expend all their energy," a South Carolina surgeon said at Chapel Hill in a Whitehead Lecture.

The next big step forward in burn treatment will be knowledge to help the patient conserve or replace his energy supply, according to Dr. Curtis Artz, chairman of the Department of Surgery at the Medical College of South Carolina.

He said that deaths from burns often are attributed to infection and lung failure when, actually, the patient loses all his energy from "a fantastic loss of protein."

Too little protein in the patient's blood may lead to weakness, swelling and poor healing.

* * *

Alcoholics can hope to find a partial solution to their problems with drugs which either reduce the craving for alcohol or which cause illness when alcohol is consumed.

The belief was expressed by a UNC psychiatrist at

the opening session of the 4th annual Summer School of Alcohol Studies.

"The chemical approach by itself is probably not enough," according to Dr. John A. Ewing, chairman of the Department of Psychiatry. "Drugs are only a part of the treatment. An alcoholic still needs to find other ways to face up to his problems."

* * *

Twenty physical therapists from 12 states, England and Puerto Rico conducted a two-week course in Chapel Hill in mid-June on treatment of patients with nerve and muscle disorders.

The short course was sponsored by the Division of Physical Therapy under a continuing education grant from the U. S. Public Health Service.

The faculty included Dr. Harrie R. Chamberlin, Dr. Richard Lee Glasser, and Marjory W. Johnson, of the UNC Medical School.

The science programs on three campuses of the University of North Carolina will be strengthened with grants totaling \$120,126 from the National Science Foundation.

UNC today was awarded \$97,857, N. C. State University was second with \$67,632 and UNC at Greensboro will receive \$22,269.

The NSF funds may be used for any science activity as long as they are spent only for direct costs.

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The University of North Carolina ranked eighth in the U. S. last year in the dollar value of training grants awarded to educational institutions by the U. S. Public Health Service.

Training grants to UNC amounted to slightly more than \$4.2 million.

The University ranked forty-eighth in traineeship and fellowship awards totaling \$142,000 and ranked twenty-first in research career program awards totaling \$347,000.

* * *

Miss Sarah Virginia Dunlap, former assistant to the dean and secretary to the faculty at the University of North Carolina School of Medicine in Chapel Hill, has been elected secretary of the John and Mary R. Markle Foundation.

Miss Dunlap left Chapel Hill last January 1 to become associate secretary of the Foundation in its New York City offices.

She became secretary in the dean's office at the UNC Medical School in 1942 and was assigned the additional duties as secretary to the medical faculty in 1956.

* * *

Contributions sent to the Chapel Hill Public Library in memory of Andy Penick are being set aside to establish a permanent memorial fund, according to an announcement just made by the Trustees of the Library. Anderson Holladay Penick was the ten year old son of Dr. and Mrs. George D. Penick of Chapel Hill and

the grandson of Mrs. Hal V. Worth and Mrs. Edwin Penick, both of Raleigh. He died on March 19 of this year.

Income from the fund will be used to purchase new books for children from 6 to 12 years of age. A special bookplate will be placed in each volume identifying the book as part of the Andy Penick Memorial Collection.

* * *

Two-year fellowships for graduate study in city planning have been awarded to Thomas C. Worth, Jr., 24, son of Dr. and Mrs. Thomas C. Worth of Raleigh, and Jonathan F. Baylin, 21, son of Dr. and Mrs. George Baylin of Durham.

Worth is presently on active duty with the U. S. Coast Guard Reserve, Cape May, New Jersey.

* * *

Dr. James H. Scatliff, radiologist at Yale University School of Medicine for the last nine years, became professor and chairman of the Department of Radiology on July 5. He is a native of Chicago, completed his undergraduate studies at Northwestern University, and received his medical degree in 1952 from the Northwestern University Medical School. His research interests are in neuro- and cardiovascular radiology.

* * *

Dr. G. Philip Manire became chairman of the Department of Bacteriology and Immunology on July 1.

He fills a vacancy created by the retirement of Dr. D. A. MacPherson, who joined the medical faculty in



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and 18 of which, in a separate area, are for patients with acute cases of chronic alcoholism or drug addiction □ Treatment procedures include psychotherapy, electroconvulsive shock therapy, subinsulin coma and chemotherapy □ *We will be pleased to provide further information upon request.*

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1923 and established the Department of Bacteriology six years later.

Dr. Manire came to the Medical School in 1950 as an assistant professor of bacteriology and immunology. He became a full professor in 1959.

* * *

Techniques of psychoanalysis were explained by a University psychiatrist in a series of lectures at the Veterans Administration Hospital in Murfreesboro, Tennessee in June.

Dr. Milton L. Miller, professor of psychiatry at UNC and chairman of the UNC-Duke Psychoanalytic Training Committee, spoke to the professional staff of the 1,200-bed neuropsychiatric hospital during an in-service training program.

* * *

Speech therapists, recent laryngectomees and laryngectomees interested in teaching esophageal speech gathered in Chapel Hill in mid-July for the first Summer Conference on the Speech Rehabilitation of the Laryngectomee.

The five-day conference is designed to train prospective teachers of esophageal speech and to offer concentrated speech therapy to a group of recent laryngectomees.

* * *

Howard Holderness, president of Jefferson Standard Life Insurance Co. of Greensboro, received one of the five honorary degrees awarded by the University at its 172nd commencement in June. He is chairman of the

Medical Foundation of North Carolina and a past president of the UNC Medical Parents' Club.

* * *

Dr. William B. Wood of the Department of Medicine has been elected president of the North Carolina Thoracic Society.

* * *

Dr. Robert R. Cadmus, head of the Department of Hospital Administration and consulting director of N. C. Memorial Hospital, has been appointed president of the New Jersey College of Medicine and Dentistry in Jersey City, New Jersey. His resignation is effective September 1. He was the original director of UNC's teaching hospital and served as director until 1962.

The New Jersey College of Medicine and Dentistry was the Seton Hall College of Medicine and Dentistry before the state assumed its operations a year ago.

* * *

Eugene B. Crawford, Jr., director of N. C. Memorial Hospital and assistant professor of hospital administration at the Medical School, has been appointed executive director of the Wilmington (Del.) Medical Center Inc. He will assume his duties in late fall.

Crawford has been director of NCMH since 1962 and had served the previous 11 years as assistant and associate director.

* * *

Hugh A. (Chip) McAllister, Jr. of Lumberton was a triple award winner at special graduation ceremonies in early June.

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Molcolm G. MacAuloy, M.D.

Phone: 344-3578

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W. E. Wilkinson, M.D.

Phone: 253-8397

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Pierce D. Nelson, M.D.

Phone: 328-2211

The 26-year-old graduating medical student received three coveted awards: the Isaac Hall Manning Award as the outstanding member of the graduating class, the Deborah C. Leary Memorial Award for the outstanding performance and ability in psychiatry.

McAllister, son of Dr. and Mrs. H. A. McAllister of Lumberton, will serve an internship next year at the Walter Reed General Hospital in Washington, D. C.

* * *

Two psychiatrists at N. C. Memorial Hospital have been honored for outstanding work on scientific reports submitted as part of their three-year residency training program.

Winners of the 1966 Anclote Manor Awards are: first place, Dr. Robert J. Daly of Sudbury, England; second place, Dr. J. Thomas Fox, Jr. of Asheville.

Dr. Daly submitted a scientific paper on "An Empirical Investigation of the Values of Various Affective Disorders."

Dr. Fox reported on "Student Help: Psychiatry at the University of North Carolina, 1956-64."

NEWS NOTES FROM THE BOWMAN GRAY SCHOOL OF MEDICINE OF WAKE FOREST COLLEGE

Dr. C. Nash Herndon, professor and chairman of the Department of Preventive Medicine and Genetics, has been named to a new administrative position at the Bowman Gray School of Medicine.

His appointment as associate dean for research development was confirmed by the trustees of Wake Forest College at their June meeting.

Dr. Herndon, who will continue to head the Department of Preventive Medicine and Genetics, will assume a larger role in the coordination and development of the medical school's research and research development programs.

A native of Greensboro, he holds the A.B. degree from Duke University and the M.D. degree from Jefferson Medical College. He was appointed to the Bowman Gray faculty in 1942.

Dr. Herndon, a past president of the American Society of Human Genetics and the American Eugenics Society, is a former editor of the American Journal of Human Genetics and associate editor of the Eugenics Quarterly. He also is a member of the editorial board for the 21st edition of Stedman's Medical Dictionary.

* * *

The John and Mary R. Markle Foundation of New York City has awarded a \$95,000 grant to the Bowman Gray School of Medicine to be used in enlarging and improving the medical school's library collection.

The grant, which will support the acquisition of medical books, monographs and periodicals, will assist the school in correcting deficiencies in certain essential areas of its library holdings. Library deficiencies at medical schools all over the United States have become increasingly acute during the past 10 years as a result of a sharp rise in the publication of new medical and scientific knowledge.

By the end of the three-year grant period, the holdings of the Bowman Gray library are expected to be comparable to those of other high quality medical schools of similar size.

* * *

Three members of the Bowman Gray faculty presented papers during June at international meetings. They were Dr. Richard L. Burt, professor of obstetrics and gynecology; Dr. A. Robert Cordell, associate professor of surgery; and Dr. Norman M. Sulkin, professor and chairman of the Department of Anatomy.

Dr. Burt presented two papers and participated in two round-table discussions June 20-22 at the Fifth World Congress on Fertility and Sterility in Stockholm, Sweden. His presentations reported on family planning studies, conducted by the Department of Obstetrics and Gynecology in cooperation with Forsyth County Health Department.

Dr. Cordell was one of three American physicians who participated in the 15th International Congress of the European Cardiovascular Society, which began June 27 in Amsterdam, Holland. He presented a paper on "Human Blood Flow Patterns with the Aortic Ball Valve Prosthesis."

Dr. Sulkin delivered the principal introductory address at the Seventh International Gerontological Congress which opened June 26 in Vienna, Austria. Speaking on "Cellular Aging and Cell Age Changes," he presented evidence that three commonly accepted concepts concerning the aging of cells are not necessarily true. These concepts, on which biologists have been in general agreement, are (a) that the structure of cells changes with age; (b) that cells lose their capabilities during the aging process; and (c) that aging cells have decreased resistance to environment.

* * *

A six-week postdoctoral training institute for family life educators was recently completed at the Behavioral Sciences Center of the Bowman Gray School of Medicine.

Directed by Dr. Clark E. Vincent, professor of sociology and director of the Behavioral Sciences Center, the institute was designed to aid other medical schools in the development of educational programs in family, marriage, human sexuality, and population control. The major objectives of the course were to prepare personnel and materials for use in the teaching, training, and research aspects of such programs.

Ten nationally-known family life educators participated in the course.

The Bowman Gray School of Medicine is a pioneer institution in family life education for the medical student. Nine years ago, only three medical schools in the United States had formal programs dealing with marriage counseling and sex education, and only at Bowman Gray was the course required. Today, 29 medical schools have committees exploring the possibility of teaching family courses.

* * *

Dr. William H. Boyce, professor of urology, presented two papers at the annual meeting of the American Urological Association in Chicago, Ill. He spoke on "General Considerations of Urolithiasis" and "Oral Adminis-

tration of Methylene Blue to Patients with Renal Calculi." Dr. Boyce was recently appointed to the editorial board of "Investigative Urology."

* * *

Dr. John W. C. Fox, assistant professor of anesthesiology, and Dr. Elisabeth Fox, instructor in anesthesiology, presented a paper on "Neuroleptanalgesia for Heart and Major Surgery" at the 115th annual convention of the American Medical Association June 26-30 in Chicago, Ill.

* * *

Dr. Clair E. Cox II, assistant professor of urology, has been appointed committee chairman of the Renal Cancer Study Group of the American Urological Association.

* * *

Dr. Timothy C. Pennell, instructor in surgery, presented a paper at a meeting of the American Association for Thoracic Surgery in Vancouver, British Columbia. His topic was "An Anatomical Study of the Peripheral Pulmonary Lymphatics."

* * *

Medical students at the Bowman Gray School of Medicine recently presented teaching awards to two faculty members and a house staffer. The clinical teaching award went to Dr. Leo J. Heaphy Jr., assistant professor of medicine. Dr. Ivan W. F. Davidson, associate professor of pharmacology received the basic sciences teaching award. Dr. George Podgorny, resident in surgery, was the recipient of the house staff teaching award.

NORTH CAROLINA HEART ASSOCIATION

Dr. A. Robert Cordell of Winston-Salem was recently installed as president of the North Carolina Heart Association, succeeding Dr. Daniel T. Young of Chapel Hill. Dr. Cordell is an assistant professor of surgery at the Bowman Gray School of Medicine.

Dr. Madison S. Spach, pediatric cardiologist at Duke University Medical Center, was elected vice president and president elect of the association.

Elected to membership on the Board of Directors were Drs. Henry Miler, Jr., Charles Glenn Sawyer, and James F. Toole, all of Winston-Salem; Drs. Arthur Freedman and James C. Bruce, Greensboro; and Ralph N. Feichter, Waynesville.

EASTERN NORTH CAROLINA NEUROLOGIC SERVICE

A neurologic clinic has been opened in Fayetteville to serve children and adults in the Southeastern part of the state who may be suffering from epilepsy or other related neurological disorders. This new service is part of a statewide program to bring scarce neurological resources to all areas of North Carolina.

The work is the product of cooperation between the three medical schools, the University of North Carolina School of Public Health, and the state and local health departments. The program is being supported in part by a grant from the Neurological and Sensory Disease Program of the U. S. Public Health Service.

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Fayetteville clinic is the second of six regional clinics scheduled to begin operation during the next three years, and is located at the outpatient department of the Cape Fear Valley Hospital in Fayetteville. Clinic sessions are held once a month. The other regional clinic is at Greenville (Pitt County).

Medical personnel will examine patients upon referral by a physician from the following counties: Bladen, Brunswick, Columbus, Cumberland, Duplin, Harnett, Hoke, Onslow, New Hanover, Pender, Robeson, Sampson, and Wayne. Neurologists from a medical center travel to Fayetteville once a month to staff the clinic with local participating physicians.

A portable electroencephalograph (brain wave machine) is provided to help in the diagnosis of various convulsive disorders. Patients referred from counties will be given complete neurological examinations and either referred back to their private physician or to a medical center for additional studies.

The objectives of the program are to find, diagnose, and bring to treatment the many persons suffering from neurological disorders particularly those not now under treatment, and to make the neurological resources of the university medical centers accessible to physicians in counties at some distance from these centers.

NEWS NOTES

Mrs. Amos N. Johnson of Garland, was elected to a two-year term on the Board of Directors of the Woman's Auxiliary to the American Medical Association during the Auxiliary's annual convention, held in Chicago in June.

The new director is noted for her civic interests. She is a member of the boards of directors of the North Carolina chapter, Arthritis and Rheumatism Foundation, and the North Carolina Council of Women; and secretary, Chapel Fund Committee, North Carolina Correctional Center.

Currently Southern regional legislation chairman for the AMA Auxiliary, Mrs. Johnson is a past president of both the Auxiliary to the Medical Society of the State of North Carolina and the Sampson County Auxiliary.

SOCIETY FOR CRYO-OPHTHALMOLOGY

The Society for Cryo-ophthalmology has been formed to promote investigative and clinical applications of low-temperature technics to the eye. Applications for membership will be welcomed from those interested in the investigative aspects of this subject, in the preservation of ocular tissue, in the therapeutic applications of cryogenics to various ocular diseases, and in cryosurgical techniques.

It is contemplated that scientific meetings will be held immediately prior to the annual sessions of the American Academy of Ophthalmology and Otolaryngology.

Inquiries and applications should be addressed to Dr. John G. Bellows, 30 North Michigan Boulevard, Chicago, 60602.

NATIONAL INSTITUTE OF MENTAL HEALTH

The first major reorganization of the National Institute of Mental Health in the 18 years of its existence has been approved by Dr. William H. Stewart, Surgeon General, U. S. Public Health Service.

The new structure of the Institute, according to Dr. Stanley F. Yolles, Director, will make possible more effective and flexible use of federal funds in support of all parts of the new national mental health program.

"The new plan of organization," Dr. Yolles stated, "will give more emphasis to clinical research, prevention programs, evaluation of treatment methods, innovative and experimental training programs, and epidemiologic studies. It will also mount an extensive attack on special mental health problem areas."

The new administrative structure establishes:

1. Four specialized program operations within the Institute as centers for the study of alcoholism, narcotics and drug abuse, suicide prevention, and metropolitan mental health problems.

2. Four centers which will coordinate all Institute activities for the study of schizophrenia; mental health and social problems (such as automation, divorce, sex deviation, poverty, race relations, leisure time); mental health of children and youth; and crime and delinquency.

3. Two model community mental health centers: one focused around a general hospital, the other based on a large state mental hospital.

4. Five associate directorships, which will administer Institute activities in the areas of: extramural research, manpower and training, mental health service programs; field investigations and intramural research.

The Institute will also sponsor experimental and special training programs to train professional and non-professional personnel in new ways for new jobs.

Continuing education programs for general practitioners and mental health professionals, including psychiatrists, will be expanded.

Two major advisory groups will continue to serve the Institute. They are the National Advisory Mental Health Council and the Board of Scientific Counselors.

What's the Score?

Eight hundred and three persons lost their lives in accidents in North Carolina in the first three months of 1966, according to provisional statistical data just released by the Public Health Statistics Section of the State Board of Health. Nearly 10 per cent more accidental deaths occurred during this period than in the corresponding period in 1965.

Motor vehicle accidents claimed the most deaths—411 during the 1966 report period; home-farm accidents claimed 256 deaths; all other accidents (occupational, non-motor vehicle transport, etc.) caused 136 deaths.

BOOK REVIEWS

Caring for the Aged. By Bertram B. Moss, M.D.
384 pages. Price, \$4.95. New York: Doubleday & Company, Inc., 1966.

As the number of people over 65 continues to increase, more and more families face the problem of looking after elderly relatives and friends. In "Caring for the Aged," an experienced American doctor looks at the problem from many different angles and comes up with specific and practical suggestions on how best to deal with it.

The author discusses specifically: housing for the elderly; the physical process of aging; adjustments in a household with children; nursing homes; diseases of the heart and blood vessels; digestive disorders; arthritis; cancer; impairment of vision and hearing; psychological and mental problems; quacks and frauds; terminal illness and death; legal and financial resources; and the provisions and implications of Medicare.

Dr. Moss has written many articles for professional journals and has appeared on television and radio. He writes with concern and understanding and also with an independent point of view that is sensible and realistic.

* * *

A Manual of Simple Burial. Ed. 3. Edited by Ernest Morgan. 64 pages. Price, \$1.00. Burnsville, N. C.: The Celo Press, 1966.

The steady drive by memorial societies and other groups to encourage the bequeathal of bodies to medical schools has resulted in a significant increase in the supply of cadavers available for medical education. Most of this increase, however, has taken place in limited areas, while other areas are experiencing increasing shortages.

A detailed report of this situation, together with a resume of the procurement policies followed by medical and dental schools in the United States and Canada, is found in the Third Edition of "A Manual of Simple Burial," recently published, with extensive revisions, by the Celo Press, Burnsville, N. C.

Also included in the manual is a comprehensive question-and-answer discussion of the legal and personal problems involved in bequeathing one's body to education or research.

The manual contains, in addition, extensive information about the personal needs and problems associated with death, with special reference to memorial societies. It should be of help to families, church groups, and others in obtaining simplicity, dignity, and economy in funeral arrangements as well as to medical schools in helping relieve the general shortage of bodies for research and education.

Some of the factors which can increase the risk of heart attack can be controlled. Some persons who reduce these risk factors will live longer. Some who don't . . . won't, says the North Carolina Heart Association.

The Month in Washington

Health manpower and medical research are being reviewed in two comprehensive studies being conducted by the federal government.

President Johnson called on the new National Advisory Commission on Health Manpower for an evaluation of the use of available government and non-government health manpower. He also asked for commission recommendations on expanding the supply of health manpower.

The Advisory Committee met for the first time a few days after the House unanimously passed and sent to the Senate a bill to train more health workers. The measure sets up a three-year, \$155 million program of aid aimed at training some 12,000 additional allied health workers such as medical technologists, therapists, x-ray technologists, dental hygienists, nutritionists, and laboratory technicians.

The legislation authorizes half the money for improving health worker training facilities and programs at qualified universities, colleges, and junior colleges. The other half would go into a program of fellowship grants and federally guaranteed loans for students.

The bill also would authorize increased student loan forgiveness for physicians, dentists, and optometrists who set up practice in poor rural areas where the supply of medical personnel is short or nonexistent.

Johnson instructed 23 Administration leaders in medicine and health matters, including Health, Education, and Welfare Secretary John W. Gardner and the directors of the national health institutes, to re-examine their priorities to determine whether research activities should be slowed down and more effort devoted toward making practical use of research findings.

He asked for a report in a few months on a general reassessment of National Institutes of Health goals, effectiveness of current medical research programs, proportions of NIH funds being spent on basic research and on applied research, and major obstacles confronting the institutes in translating research into practical benefits.

The President was reported to have shown concern in a meeting with his top medicine and health advisors that too much is being spent "for the sake of research alone." Similar concern has been voiced by some non-government individuals knowledgeable in the health field.

National expenditures for medical research have increased from \$87 million in 1947 to an estimated \$1.85 billion last year. About two-thirds of the 1965 total federal money and about four-tenths of the total was administered by the National Institutes of Health. In the two decades following World War II, NIH annual appropriations have zoomed from \$3 million to \$1.25 billion. In recent years, Congress voted NIH more money than the Administration has requested.

"The National Institutes of Health are spending more than \$800 million a year on biomedical research," Johnson said. "I am keenly interested to learn not only what knowledge this buys but what are the pay-offs in terms of healthy lives for our citizens. . .

". . . The nation faces a heavy demand on its hospitals and health manpower. Medical research, effectively applied, can help reduce the load by preventing disease before it occurs, and by curing disease when it does strike.

"But the greater reward is in the well-being of our citizens. We must make sure that no life-giving discovery is locked up in the laboratory."

* * *

The Food and Drug Administration has issued new regulations tightening the requirements for special diet foods and diet supplements.

The revised regulations are aimed at providing the consumer with more facts about the foods for weight control, for dietary supplementation with vitamins and minerals, and for other special diet needs, such as controlling salt intake, according to Dr. James L. Goddard, the head of FDA.

The new regulations set standards for certain foods to which nutrients may be added only if they have real value. A Recommended

Dietary Allowances also is included as a guide to meeting nutritional needs.

The new regulations will prohibit extravagant promotion of "shotgun" multi-vitamin and mineral supplements containing nutrients that meet no dietary need and tend to deceive the consumer.

The revised labeling regulations and the new standards for fortified foods and vitamin and mineral supplements are scheduled to become effective in December.

A general revision of regulations on special dietary foods and vitamin-mineral supplements was proposed by the FDA four years ago. More than 50,000 comments were received on the provisions suggested at that time. The new regulations are the result of a review of the 1962 proposals and the comments and recommendations received about them.

Goddard said the new requirements should sweep away many of the common misconceptions about the kinds and amounts of vitamins and minerals needed in the diet, and how they are obtained. He said "most Americans eat foods that provide all the vitamins and minerals normally required for good health."

Multi-vitamin and mineral products will be required by the regulations to bear the following label:

Vitamins and minerals are supplied in abundant amounts by the foods we eat. The Food and Nutrition Board of the National Research Council recommends that dietary needs be satisfied by foods. Except for persons with special medical needs, there is no scientific basis for recommending routine use of dietary supplements.

The Pharmaceutical Manufacturers Association said that the new restrictions are "not in the public interest." A spokesman for the association said that when the Food and Drug Administration proposed similar regulations in 1962, "we found serious differences of opinion among nutritionists and other scientists as to the scientific basis for the proposals."

A spokesman for the National Health Federation, predicted that consumers will rebel against the regulations. He promised, "Congress will get more letters on this than on any other issue—any other." The federation is an

organization of the manufacturers and distributors of unusual "health foods" and "super" vitamins.

The Drug and Allied Products Guild, composed of smaller drug manufacturers and distributors, voted authority for its officers to assess the 97 regular members up to \$500 each to hire special lawyers to prepare arguments against the FDA regulations.

* * *

HEW Secretary John W. Gardner plans to reorganize the Public Health Service to give the Surgeon General more control over eight new divisions which would replace the present eight.

One of the new eight major divisions would be a National Institute of Mental Health which is now lumped under the National Institutes of Health. The new national institute will include the Forth Worth and Lexington Narcotics Hospitals and will "administer a unified program of research, manpower training, demonstrations, and mental health services." Gardner said the institute will "serve as the principal focus for research and control programs in alcoholism and drug addiction."

The other seven new divisions would be the National Institutes of Health, the Bureau of Health Services, the Bureau of Health Manpower, the Bureau of Disease and Injury Prevention and Control, the National Library of Medicine, the National Center for Health Statistics and Surgeon General's office.

Gardner's Public Health Service reorganization plan transfers to the secretary all functions of the Public Health Service, the Surgeon General, and all other agencies in the service. Gardner called the present structure of the Public Health Service "obsolete." He pointed out it was unchanged since 1943

when the service had a budget of \$52 million compared to the present budget of \$2.4 billion.

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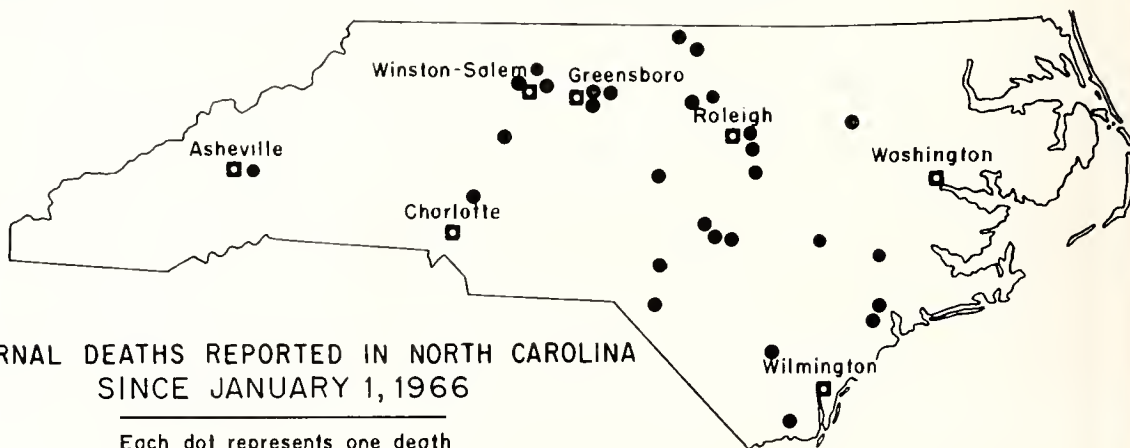
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MEDICAL JOURNAL

PUBLISHED MONTHLY BY THE MEDICAL SOCIETY OF THE STATE OF NORTH CAROLINA

IN THIS ISSUE:

A Civil War Surgeon's Diary

LOUIS SHAFFNER, M.D.

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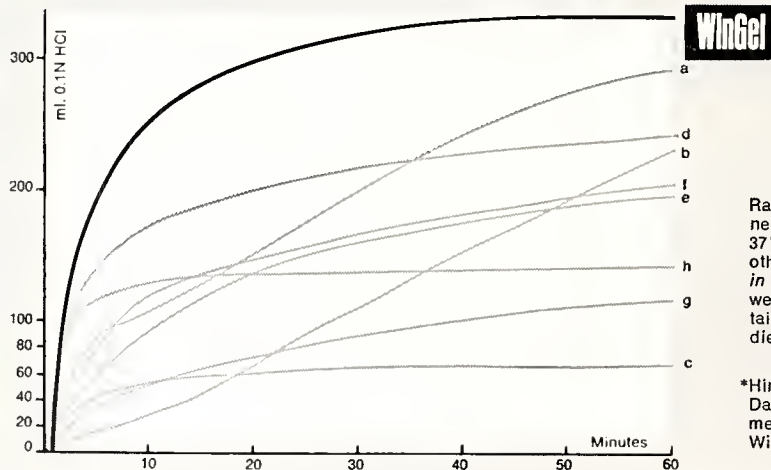
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VOLUME 27

SEPTEMBER, 1966

NUMBER 9

A Civil War Surgeon's Diary

LOUIS SHAFFNER, M.D.

WINSTON-SALEM

In June 1861, Francis Fries, a businessman of Salem, North Carolina, wrote a long letter of encouragement and advice to a private rifleman camped at Danville, Virginia.

"You have been like all ardent young men," he said, "too easily carried away by the honeyed words of pretended friends and by the passing excitement of the day. You have now had an opportunity to learn practically what reliance can be placed in the verbal and written promises of high officials, the insipid blarney of a private secretary, and even the apparently frank declarations of a Surgeon General that powers conferred on him by the convention would enable him to be of service to you."

The private was Dr. J. F. Shaffner, 22 years old, a full year out of Jefferson Medical College, and his application for a commission as an Assistant Surgeon in the North Carolina Troops of the Confederate Army had been passed over. He had written of his chagrin to his older friend who had helped finance his medical education.

"Let us hear from you often and unreservedly," the letter concluded. "Impart to us your joys and your sorrows, your fears and your hopes. It would be a relief to you to have a place to unburden your mind without fear of having your confidence abused. Most sincerely your friend and well-wisher, Francis Fries."

So, write the young doctor did, letter after letter, for four years of the Civil War, a few directly to the businessman, but most to the businessman's daughter, Carrie. From 1861 through 1862 the salutations were "Dear

Friend," with a closing of "Yours truly." In 1863 and 1864 they were "My dearest Carrie" and "Affectionately yours," and in 1865, "My beloved wife," and "Your devoted husband."

For editorial comment see page 445

In addition, he kept a day-by-day diary of his activities. He eventually obtained his commission as Assistant Surgeon and was first in battle in the swamps near New Bern, North Carolina. Later he was surgeon with the 33rd and 4th Regiments of North Carolina Troops and served as Brigade Surgeon in Branch's and Ramseur's Brigade in the Army of Northern Virginia until the surrender at Appomattox in April, 1865.

The first half of the diary was lost in a fire, but the latter half and the letters remain. They afford a most interesting and informative account, not so much of the details of military medicine, but rather of the daily chores, frustrations, boredom, impressions, personality clashes, friendships, and hardships experienced by a field surgeon. Anyone who has had active service as a medical officer can find incident after incident with which he can be sympathetic. Although medical and military knowledge and capabilities change, human nature remains the same, both the good and the bad of it.

The doctor wrote:

The position I hold is unpleasant and ungrateful, in fact such is the general complaint of the surgeons. Many men are disposed to feign sickness, and detecting this, duty demands that the offender be put on duty. Again the surgeon has constant applications for discharges, and especially for furloughs. Refusing to grant these, the common, uneducated soldier blames

Read before the North Carolina Surgical Association and the Virginia Surgical Society, Hot Springs, Virginia, April 30, 1966.

From the Department of Surgery, Bowman Gray School of Medicine of Wake Forest College, Winston-Salem, N. C.

the doctor, not stopping to remember that we too have duties to perform and rules to guide us. The Assistant Surgeon has advantage in these, being scarcely ever compelled to act so decisively. While Dr. Baker was surgeon he was continuously being cursed by a certain class—now I get the full benefit.

During the early days of the War there were severe epidemics of typhoid fever, measles, mumps and dysentery. In September, 1861, he wrote hastily "600 sick to look after and me to do alone."

Later during the campaigns there was much activity, forced marches, irregular rest and food, fatigue, and battle casualties. At all times there were sick calls, written reports and requisitions, transfers, etc.

During the winters there was little additional to do except try to stay warm and dry amidst the cold, rain, snow and mud. Brief entries in the diary tell much. One reports: "Witnessed the execution of Privates Owens, Sparks, and Wyatt, all of Co.E-convicted of desertion." Another was: "Solemnly vowed never again to play a game of poker—as I am even now neither winner or owing anything."

The regimental surgeons had their own wagons with tent and equipment. With the help of a colored servant they cooked their own meals. They owned their own horses but were entitled to draw forage for them.

During battle the Assistant Surgeon was forward with the troops and the Surgeon remained with his helpers about a mile in the rear, at the field infirmary, to receive the wounded and move them by ambulances, as needed, to field hospital.

After a severe battle involving many casualties, the opposing armies would occasionally observe a temporary truce to allow each side to send ambulances onto the battlefield to collect the dead and wounded. Should one army retreat behind its field infirmary, the surgeon, to avoid capture, might decide to leave his severely wounded and then return under truce later to retrieve them. But this was risky.

Of the Battle of Hamner Court House, May 27, 1862, the doctor wrote:

Against this unequal and superior force we fought with varying success. At last we were compelled to retreat, which was effected in good and perfect order.

In the advance with my Regt. I received an order from Gen'l Branch to have all the wounded removed to Ashland that our transportation could carry. I forthwith rode to our field Hospital, and communicated the Gen's. order to Surgeon Miller, Brigade Surgeon, who most disgracefully mounted his horse, as did two other Surgeons, and left the wounded, ambulances, instruments and supplies lying unprotected in the yard. Feeling that this was useless panic and waste of property, I stopped, loaded all the ambulances with the slightly wounded, got off all instruments and medicines and whatever was of value, just before the enemy succeeded in surrounding the house. Some 30 wounded I thus succeeded in getting away, all that were saved from capture. There were still about 20, badly wounded lying in the house, and finding it impossible to get away, the last ambulance sent off, already in the hands of the enemy, I could do nothing but remain with the wounded. During the night I picked up about 20 more of our wounded, and was busily and alone engaged in performing operations, dressing wounds, &c., until 1 o'clock in the morning.

At daylight we were all moved 2 miles McClellanward, and remained at a private residence, converted into hospital, until the following day; when we were again removed, and this time to the left bank of the Chickahominy, distant 15 miles from battlefield. Here in a barn hospital, I remained with the wounded (for three weeks) until last Tuesday, being then transferred with the wounded to Fortress Monroe. Arriving at Fortress Monroe on Wednesday, we left per flag of Truce on Thursday, reached City Point near Petersburg the same evening, and this place (Richmond) yesterday morning. My release is "Unconditional" and I have reported to the Surgeon General for duty.

The horrors of the battlefield are bad, but oh not one particle so affecting as those of the hospital with wounded. The suffering of the poor wounded soldier, his prayers, his constant calls for absent ones at home, &c., are almost heart-rending. 'Tis true we are apt to become hardened by association with these things—still humanity convinces us all that such sufferings are terrible. Surgeons are in evergrowing danger of becoming too abstract—of losing sympathy with passing emotions and sufferings, and particularly with those shared by numbers. The danger is, lest we forget that we too are mortal; subject to same dangers, and fancy ourselves superior to our former selves, because now, at present we do not feel the pains, the agonies of the poor sufferers in our charge. But I shall never forget these scenes of anguish and pain—they make lasting impressions upon my mind. But I am getting too verbose and running into abstract reasoning.

The Surgeon General would rather place me in a Hospital here, but I prefer the active life of the field."

The doctor returned to his regiment and full duty through the fall of 1862, at the 2nd Battle of Bull Run, and at Antietam, and in 1863 at Chancellorsville and Gettysburg.

From camp near Hagerstown, Maryland on July 8, 1863 he wrote:

Soon the enemy marched out to meet us, and our advanced lines became engaged near Gettysburg, where finally was fought one of the bloodiest battles of ancient and modern times. The first days, our army succeeded in driving the enemy for miles, killing and wounding many and capturing thousands of prisoners. The third day they had taken position upon a series of hills, which they very soon fortified, and thus rendered impregnable. Against this position our men were led several times, and repulsed. Our loss in killed, wounded and missing was very heavy.

As usual N. C. suffered severely. Capt. Wheeler of 2nd Battalion was severely wounded. A shell or fragment of shell, wounded him in both legs, and so shattered his left hand, that amputation of arm above the wrist-joint became necessary. When I last saw him he was doing as well as could have been expected under circumstances. He was left a prisoner in the enemy's line. Henry Bahnson remained with him as nurse.

Our entire loss it would be difficult to estimate now, but I fear it will reach nearly 20,000 in killed, wounded and missing. Some five thousand are probably prisoners. About four thousand wounded were left near battlefield for want of transportation. We have taken a large number of prisoners, the exact number I do not know, but am sure not less than eight thousand. The loss of the enemy is also very heavy, but we have had no opportunity yet of learning particulars. The enemy will certainly claim a great victory as usual. We have voluntarily left the battle-field and abandoned a large number of wounded, but our falling back was slowly accomplished, and none followed in our rear. The Cavalry annoyed our communication, therefore it became necessary to cover it by a fall back to this point. We lost no Artillery, but captured several batteries. The enemy destroyed some 50 wagons and 25 ambulances of our train—we captured more than 200 wagons and some 46 ambulances. Besides these we pressed numbers from citizens. This campaign has been arduous and bloody, of its results we cannot yet speculate. Here we will evidently remain several days to recruit and then off again, but whither we know not. Please let my parents know that you have this letter.

Soon, however, he went home on sick leave because of jaundice, and returned to duty in September. The following is the diary for the week of October 9 through October 16, 1863.

October 9

At midnight we were aroused, receiving orders to be ready to move by four o'clock A.M. . . . Weather very cool and frosty. Left camp at half past five . . . marched steadily until we reached Orange C. H., distant 15 miles, thence to Rapidan, distant 4 miles, which we crossed and encamped in a fine grove 2 miles beyond the river. Whole distance made since morning 22 miles. It is reported that the enemy has fallen back. The news from Chattanooga reports Gen'l Bragg to be shelling Chattanooga from Lookout Mountain. The enemy are strongly fortified in the town . . . Received letters from Mollie and C., also a short note from Emma . . . Weather clear and cold.

October 10

Resumed the march this morning at half past five o'clock. Four conscripts from our regt. deserted last night. The Division of Gen'l Early follows ours. About noon we left Madison C. H. to our left & passed beyond it. Our march was through fields and woods—following ravines as much as practicable, avoiding all the hills we could—probably to cover the movement from the eyes of the enemy . . . Went supperless to bed.

October 11

Cool, clear morning. Resumed our march at seven o'clock. Our men are very much fatigued. Eat breakfast of Bacon, hard bread and sweet potatoes. At two o'clock went into camp five miles from Culpepper C. House on the Sperryville pike. Passed through deserted camps of the enemy who has evidently retreated. Some hundred or more prisoners have been brought in—captured in the advance.

October 12

A frosty morning. Resumed our march at half past five o'clock. The enemy has fallen behind the Rappahannock. A sharp cavalry fight was made at Brandy Station in which the enemy was driven and we captured some prisoners. We took the road for Warrenton. In our march we passed by a number of troops belonging to A. P. Hill's Corps, bivouacked along the road. Reached Jeffersonson near Warrenton Springs, about three o'clock . . . here a sharp cavalry skirmish ensued . . . the enemy was driven off. At the Ford at Warrenton Springs the fight between the Cavalry was quite severe. The enemy was defeated, leaving in our hands more than 200 prisoners, many horses, and his dead and wounded . . . At night we crossed the river, encamped on the Pike leading to the turn of Warrenton . . . A small ration of beef was issued to-day. No salt or bread.

October 13

A clear and cold morning. Resumed our march at day-light. Reached the town of Warrenton about 9 o'clock, where a halt of six hours was made. In the evening we took up Camp one mile east of town, where we cooked rations for three days. Cannonading is heard in our front.

October 14

Resumed march at five o'clock. The morning is damp and cloudy . . . Our advance guard was suddenly and unexpectedly fired upon by the enemy, whom we found drawn up in the line of battle, one mile from our camping ground of the previous night. Our brigade was in the front. Soon drove in the skirmishers of the foe.

The following soldiers wounded reported to me: Priv. Chas. Turmige, Co. I. Flesh wound of the left shoulder. Removed the ball from beneath scapula . . . Priv. C. T. Arthurs, Co. C. Amputation of fore finger of right hand . . . Priv. J. T. Owens, Co. K. Flesh wound of scalp. Sergeant Hunter, Co. A. was killed. After a sharp contest the enemy was routed, leaving his dead in our possession. Proceeded on the road towards Bristol Station. Rapid and heavy firing ahead. We soon learned that Cooke's & Kirkland's brigades of N. Carolinians had advanced upon a heavy fire of the enemy in a railroad cut, and been repulsed with a loss of 800 killed and wounded—400 prisoners and 6 pieces of Artillery. Camped for the night, near the battle field.

October 15

Rained some during the night. Lying idle in camp this morning. During the night the enemy retreated. An entire Regt. of his was captured to-day by our forces, the commanding Officer being drunk. Wrote a letter to C. at night.

October 16

Rained all night, still at it this morning, no orders so far to move . . . Paid a visit to Mr. Lynn's family, distant from our camp 11 miles. Two years ago, while our Army was at and around Canterville & Mannassas Junction, I, being Asst. Surgeon in 21st N. C. Regt., was taken ill with **Feb. continuus**. Mr. Lynn took me in his house where I was kindly nursed and cared for by Mrs. Lynn. A year ago, during the campaign against Pope, I visited the family again. Felt anxious to see them now.

When I got to the house I found that two sons have died with fever, & the mother and eldest daughter very low with same disease. Was furnished with a good dinner. While there it rained very hard. On my return I found the creeks greatly swollen, could scarcely cross. My horse had to swim one with me. When I returned to Camp it was almost night, and I found that the brigade had moved five miles backward, engaged in destroying the Orange & Alexandria Railroad. The whole Army being at it, the work was thoroughly and rapidly executed.

After this the regiment went into winter quarters, and the strain was beginning to tell on everyone. "The greatest want is in blankets and overcoats. Many hundreds of men lie out every night without overcoat or blanket, and thousands have only one or the other. Large fires are kept up, and in this wise

they keep from freezing. Still it is an unhealthy mode of rest and an imperfect one."

In January, 1864, he wrote: "The question of subsistence has become a serious one, and we must endeavor to draw supplies from enemy's country."

Then appears in the diary and the letters these events. All officers were expected to do duty unless excused by the Surgeon. A Captain McRine did not go on picket, and had not reported to the Surgeon that he was sick, but did so report to the Adjutant's office. The Colonel, finding this out, ordered the doctor to examine him and report in writing. He did so and reported him sick but not seriously. Four days later this entry.

January 10

Cold, clear morning; it is Sunday.—Wrote letter to C.—Col. Grimes issued to me the following order:

Hd. Quarters 4th N. C. Troops

Jan. 10th, 1864

Surgeon Shaffner, Will examine Capt. McRine, and report his condition to these Hd. Quarters.

Bryan Grimes, Col. 4th N. C. Tr."

This is the second time I have been ordered to examine Capt. McRine, and it is getting unpleasant.—Last Wednesday I did so under orders.—Upon examining the Captain this morning, I reported in writing thus:

Med. Dept. 4th N. C. Trps.

Jan'y 10th, 1864

Agreeable to orders, I have examined Capt. McRine and find him complaining of Lumbago, Dyspepsia & Diarrhoea; of the latter there are symptoms—the former must be aggravated to be distinguished.

Respectfully, J. F. Shaffner, Surgeon

I hope this will be the last time I shall be required to examine this Captain—In the evening the Adjutant sent me this order:

Hd. Qrs. 4th N. C. Troops

Jan'y 10th, 1864.

Surgeon Shaffner,

I am directed by Colonel Grimes to say to you that either you or your Asst. Surgeon must examine Capt. Wm. F. McRine (3) three times each day and report to this office in writing.

I am Most Respectfully

Yours, &c.

Wm. S. Barnes Adj't.

At the same time the Adj't showed me the following.

Hd. Qrs. 4th N. C. Troops

Jan'y 10th, 1864.

Special Order No.

Hereafter Company Officers when sick, will report to the Surgeon in person or through their orderlies, or they will be considered for duty.

By order of Col. Grimes
Wm. S. Barnes, Adj't.

The first to me is illegal, unnecessary and tyrannical.—I almost feel inclined to refuse compliance. Since however the Capt. will be required to come to my tent. I will, for the sake of harmony, yield to compliance. I sent a copy to Capt. McRine. I have a very sick man in Co.H., by name of Horn. Disease—Typhoid Fever. I am afraid he will die . . . Received letter from Capt. Pfohl.

January 11

Cold, clear morning. Covered my horse stable. Received a letter from Mr. A. F. Pfohl. Private Horn died this evening.

January 12

A clear, not very cold morning. Hauled logs to build me a kitchen. Received orders to appear as a member of Med. Examining Board. The following note I received:

Hd. Qrs. 4th N. C. Troops
January 12th, 1864

Surgeon Shaffner.

Col. Grimes desires to know if you obeyed the order of Jan'y 10th, requiring you to examine Capt. McRine three times each day.

Respectfully
W. S. Barnes, Adj't.

I replied thus:

Med. Dept., Jan'y 12th, 1864.
Adj't W. S. Barnes,
Sir

I was about my tent all day yesterday, prepared to examine McRine whenever he presented himself.—He having failed to do so—I had no report to make.—Please inform Col. Grimes of this.

Respectfully,
J. F. Shaffner
Surgeon 4th N. C. Tr.

Then came the following:

Hd. Qrs. 4th N. C. Troops
January 12, 1864

Dr. Shaffner,

Col. Grimes directs me to inform you that you must visit Capt. McRine in his tent immediately, and report his condition in writing by 12 o'clock M. to-day.

Yours respectfully,
W. S. Barnes, Adj't.

For the first time, I now felt indignant. My impulse is not to obey—prudence and judgment induce me to yield. The following is my report:

Med. Dept. Jan'y 12th, 1864

Adj't. Wm. S. Barnes,

Sir, I have examined again, Capt. McRine, and find he is still complaining with Rheumatism & Dyspepsia and Diarrhoea; There are symptoms of the latter the former must be aggravated to be distinguished.

Respectfully
J. F. Shaffner
Surgeon 4th N. C. Tr.

Soon after I received this order:

Hd. Qrs. 4th Regt. N. C. S. Tr.
Jan'y 12, 1864

Dr. Shaffner,

Col. Grimes directs me to inquire of you again if you obeyed his orders issued through me on the 10th, and if not, your reasons in full for disobeying the order.

Respectfully
W. S. Barnes Adj't.

My reply:

Med. Dept. Jan'y 12, 1864

Adjutant Wm. S. Barnes,

Sir, The Medical regulations require that the sick shall visit the Surgeon, if able to do so. The Medical Officer the sick in their quarters when not; this influenced my actions. Surely Col. Grimes did not expect me to visit Capt. McRine in his tent three times each day, for this would be punishment to me alone.

Respectfully,
J. F. Shaffner Surgeon

Hd. Qrs. 4th N. C. Troops
Jan'y 12, 1864

Dr. Shaffner,

Col. Grimes directs me to inquire of you again if you complied with the order of Jan'y 10th, and requires a categorical answer to the question from you.

Respectfully,
Wm. S. Barnes, Adj't.

My reply:

Med. Dept. Jan'y 12th, 1864

Wm. S. Barnes, Adj't.—I did not, because Capt. McRine did not present himself for examination.

Respectfully,
J. F. Shaffner, Surg.

So ends the correspondence with to-day. I must confess I regret this exceedingly. The relations between Col. Grimes and myself have heretofore been of a pleasant nature—this difficulty must necessarily mar them. I have the great comfort however, that this is not of my seeking. Whatever the result, I am not responsible. One iota I will not budge, a court-martial must now determine who is in the wrong.

January 13

Wrote a letter to Mother.—Cloudy cold morning.—Mr. Cavin commenced work upon his kitchen to-day.—Wrote to Messrs. West & Johnston of Richmond with inquiry why he had not sent St. Denis as ordered.—I was placed in arrest this evening by the following order:

Hd. Qrs. 4th N. C. S. Troops
Jan'y 13th, 1864

Dr. Shaffner,

Col. Grimes directs me to say to you that you may consider yourself in arrest for disobedience of orders.

Yours Respectfully
Wm. S. Barnes, Adj't.

Received a letter from C., whose affectionate expressions did much towards cheering me, in this my hour of trial and trouble.

January 14

Clear and pleasant morning.—Capt. Pfohl paid me a visit to-day.—We spent a pleasant day.—Wrote letter to C. telling her of my arrest, &c.

January 15

Warm and cloudy morning.—Rained a little last night.—The following note I sent to the Adj't's office:

Med. Dept., Jan'y 14, 1864
Adj't Wm. S. Barnes,

Sir, If charges have been preferred against me by Col. Grimes, I respectfully ask that a copy be sent me.

Respectfully,
J. F. Shaffner, Surgeon

Wrote letters to Sallie and Col. Belo. Col. Grimes has been catechizing my Steward to find out something against me, as an additional base of charges.

Charges and specifications included disobedience of orders, conduct unbecoming an officer and gentleman, and conduct to the prejudice of good order and military discipline.

The doctor pleaded his own case before the court. Of the first day he wrote:

March 17

Promptly at 9½ o'clock, I appeared at Military Court Assembled. After mature deliberation, I determined to summon witnesses to prove Col. Grimes' character and general disposition. This determination I arrived at after considerable hesitation, but recollecting that he is endeavoring to disgrace me and mine, by the foolish prosecution of charges, upon no foundation whatever, I concluded it would be a false delicacy to leave any stone unturned to prove my innocence. For the

purpose of proving his character I summoned Captain Kelly & Lt. Jones, Co. G., to appear at the trial. The trial was called at 11 o'clock, Col. Grimes being the first witness. He testified in a violent and passionate manner, endeavoring to leave the impression with the Court that I am a scoundrel of the darkest dye. I made him however admit many things in my favor, and upon the whole I do not think his testimony has damaged me any.

In his final plea he said:

March 22

My inference was natural; the thought never occurred to me that I was to visit Capt. McRine tri-daily! Why should this have been expected of me? Twice I had already reported Capt. McRine sick, (See Col. Grimes' testimony of proceedings of Jan'y 6th and Asst. Surg. Hadly's of my examination of Jan'y 10th) neither did his condition require such assiduous attention!—I presumed, as did Asst. Surg. Hadly (see his testimony) that the object of the order, was to compel Capt. McRine to report for duty, by this mode of punishment, and by requiring me to go to McRine's tent, the punishment would have been with me alone.—And to this point I bespeak especial attention.—Viewed in this light, as only it can be, the order of Jan'y 10th must be considered tyrannical, and not free of reproach.—If Capt. McRine had been ordered to report to me tri-daily for examination (as I expected he would be) I should have received him kindly, and reported in writing, as directed.—My object has ever been to obey orders of my Superior Officers, only considering the interests of the public service, and never regarding self, well aware that personal feelings and private dignity ought to yield to public authority.

Time passed and the entry of April 4th reads:

April 4

Commenced snowing about 11 o'clock, but it soon changed to rain. Dr. Logan visited and dined with me to-day. I received the following from the Adj't about noon:

Hd. Qrs. 4th N. C. Troops
April 4, 1864

SPECIAL ORDER NO

Surgeon J. F. Shaffner, having been acquitted of the charges preferred against him, is released from arrest, and will report for duty.

By order of Col. Grimes
Wm. S. Barnes, Adj't.

The following is the official notification of my acquittal, received at Reg'tl Hd. Qrs.

Hd. Qrs. Dept. N. Va.
April 2, 1864

Acquittals by Mil. Ct. 2nd Corps

5. Dr. J. F. Shaffner, Surgeon 4th N. C. Troops.

General, I am directed by Gen'l Lee, to notify you of the above acquittals, in order that the prisoners may be released from arrest & restored to duty.

Very Respectfully,

Your Obedt Sv't.

(Signed) H. E. Young, J. A. Gen'l.

To Lt. Gen'l Ewell Com. &c.

Official (Signed) A. S. Pendleton, A.A.G.

Official (Signed) R. R. Hutchinson, A.A.G.

Official Seaton Gales, A.A.G.

At last now my suspense is relieved. As I hoped from the commencement of the difficulty, an acquittal has been rendered . . . Received letters from Sallie. Wrote to C., and Sallie . . . also receipted for Whiskey to Surg. Geddings, Medical Purveyor, A. N. Va., & for Medical & Hospital supplies for last month to Surg. J. W. Hines, Med. Purveyor at Richmond . . . Still raining and hailing and snowing."

On a cold, wet, raw night after the court martial the regiment was ordered to guard a covered bridge across the Rapidan. The men were quartered in the bridge, and in an effort to keep warm they built large fires of rails on the bridge. The bridge caught fire several times during the night.

The next day, General Lee and his staff rode by, and seeing the bridge had been burned, inquired for the Commanding officer. Colonel Grimes was found, informed that charges would be preferred against him, and ordered to consider himself under arrest. The doctor's comment was, "The biter at last is bitten."

Enlisted men had their problems too, and one wrote to his captain:

Der Sir, as i am the accused of Being distant without leaf which is all so i now renounce the facts before the ornible Court it was on a Count of disability which i did not feel sofishment (for this) Campaign as i hope i have as good a Suthern hart as any man ort to have i now leav it with the orinible Cort to dispenc of as tha think propper. E. Barkley—Yours Truley.

So went the war for one surgeon. Still another year to fight. The last diary entry reads: "February 5, 1865 About 4 P.M. the troops were hurriedly marched out—no one knows whither.—I did not accompany them, as I am on the point of leaving for home."

Much has been made of the ill effects of tea in the diet. They are, no doubt, numerous; but they proceed rather from the imprudent use of it, than from any bad qualities in the tea itself. Most delicate persons, who are the greatest tea-drinkers, cannot eat anything in the morning. If such persons, after fasting ten or twelve hours, drink four or five cups of tea, without eating almost any bread, it must hurt them. Good tea, taken in moderate quantity, not too strong, nor too hot, nor drunk upon an empty stomach, will seldom do harm; but if it be had, or substituted in the room of solid food, it must have many ill effects.—William Buchan: Domestic Medicine, or a Treatise on the Prevention and Cure of Diseases by Regimen and Simple Medicine, etc. Philadelphia, Richard Folwell, 1799, p. 62.

Factors Affecting Therapy in Endometrial Cancer

HUGH M. SHINGLETON, M.D.

AND

THOMAS D. GUIN, M.D.*

Management of patients with the diagnosis of carcinoma of the uterine fundus presents many problems. Since North Carolina Memorial Hospital is a referral center for physicians throughout the state, an evaluation of patients treated at this hospital and recommendations for the management of this disease should be of interest to these practitioners. Between 1952 and 1965, 174 patients with endometrial carcinoma were admitted to the Gynecology Tumor Service. During the same time interval, 963 patients with cervical cancer were registered, a ratio of 1:5.5.

Table 1 lists the type of treatment given 138 patients who received their primary therapy at this hospital. Ninety, or 65% of the

Table 1
Treatment of Carcinoma of the Endometrium
(1952-1965)

	No. Patients
Combined irradiation surgery	76
Irradiation only	48
Surgery only	14
No treatment	5
Previous treatment elsewhere	31
Total	174

treated patients, had hysterectomy as part of their therapy. Thirty-one patients previously treated at other hospitals received further therapy or follow-up. Five patients either refused therapy or received none because of advanced disease. The hospital record of each of these patients has been carefully reviewed to delineate those factors which alter management and affect survival. Five interrelated areas appear to be of great importance.

Medical Problems

The medical problems of patients with endometrial carcinoma are well known. Most

of the patients are menopausal or postmenopausal; they tend to be obese, hypertensive, and diabetic. Because of these conditions, operability becomes a factor in determining management. The operability rate in this series was 65%, somewhat lower than in other reported series.^{1,2} Thus, a third of the patients did not have surgery, usually considered part of the therapy for this disease.

The staging method for endometrial carcinoma adopted by the International Gynecological Congress³ considers two factors: (1) Is the tumor confined to the uterus? (2) Is the patient operable? Table 2 lists the results according to this staging system in those patients treated before May, 1961. The 44 surgical patients had a 79.5% five-year survival rate, while the 25 nonsurgical patients had less than 13% survival. The majority of the latter group, however, were inoperable because of widespread cancer. Since hysterectomy as part of the therapy appears to increase the chance of survival, patients whose medical problems are not severe should be offered surgery. The slightly increased operative risk seems justified in the face of a significantly increased chance of survival. In a few patients in this series, surgery was not performed because of relatively minor medical problems; more of these patients died of cancer in the ensuing five years than of intercurrent disease.

Extent of Tumor

Pre-treatment Evaluation: Before deciding upon the treatment program, three questions should be answered:

1. Is the tumor confined to the uterus? The patient with confined tumor will have the best chance of survival. The patient with tumor beyond the uterus but within the pelvis may be a candidate for radical or exten-

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Table 2
Five-Year Survival Related to Operability—All Treatment
1952—April, 1961

International Stage of Tumor		No. Patients	Living	Dead of Cancer	Dead of Intercurrent Disease	Lost	Percentage Survival
Stage I	Confined to uterus						
Group I	Operation advised	44	35	5	3	1	79.5
Group II	Operation not advised	8	1	3	3	1	12.5
Stage II	Tumor outside uterus	17	2	14	1	0	11.8
Totals		69	38	22	7	2	55.0

cludes any surgery and makes the patient a candidate for palliative therapy only.

2. Is the uterus enlarged? As the size of the uterus increases, the patient's chance of survival decreases. This is probably related to the fact that fundal carcinoma tends to stay confined to the endometrial cavity until the late stages, often filling the cavity and causing enlargement of the uterus. Gusberg^{2,4} suggests the following system of staging:

Stage I—normal size uterus (sounds 3 inches or less)

Stage II—slightly enlarged uterus (sounds 3-4 inches)

Stage III—markedly enlarged uterus (sounds 4 inches or more)

Stage IV—tumor outside the uterus
(If endocervical involvement is present or if the tumor is markedly anaplastic, the case is advanced one stage; for instance, a Stage II case would become Stage III)

The relationship between uterine size and five-year survival both in the all-treatment group and in the radium-hysterectomy group is shown in Table 3.

3. Is the endocervix involved with tumor? Involvement generally means a poorer prognosis and requires different therapy.^{2,4,5} Endocervical as well as uterine curettage should

be done if endometrial cancer is a possibility. Because of the importance of endocervical involvement and the lack of discussion of this additional factor in most reported series, it is discussed in more detail below.

Residual cancer in operative specimen following radium: More than one half of the patients treated with radium followed by total hysterectomy will have residual tumor in the operative specimen. The larger the uterus, the more difficult it is to eradicate tumor with preoperative radium. Such residual tumor lessens the chances of survival, especially if the myometrium is invaded. If the tumor involves the adnexal structures, the prognosis is even poorer. Patients with deep myometrial involvement or adnexal spread might benefit by external irradiation to the pelvis following surgery; Price⁶ noted improved survival and fewer vaginal cuff recurrences with this type of management.

Unsuspected cancer: Finding unsuspected cancer in surgical specimens when the indication for hysterectomy was not cancer led to the referral of a number of patients to North Carolina Memorial Hospital. This situation has occurred only once in the hysterectomy series at this hospital. The patient had large fibroids and irregular bleeding; a dila-

Table 3
Five-Year Survival Related to Uterine Size
(1952—April, 1961)

All Treatments							Preoperative Radium and Hysterectomy					
Stg.	No. Pts.	5-yr. Survival	Dead of			% Survival	No. Pts.	5-yr. Survival	Dead of			% Survival
			Cancer	Intercurrent Disease	Lost				Cancer	Intercurrent Disease	Lost	
I	30	20	5	4	1	66.6	17	15	1	1	0	88.2
II	21	15	5	1	0	71.4	16	11	4	1	0	68.8
III	9	2	4	2	1	22.2	5	2	1	1	1	40
IV	9	1	8	0	0	11.1	1	0	1	0	0	0
Total	69	38	22	7	2	55.0	39	28	7	3	1	71.8

tation and curettage prior to the hysterectomy failed to reveal any evidence of cancer. In the operative specimen a small area of carcinoma was found. Abnormal bleeding or discharge makes a diagnostic curettage mandatory prior to any hysterectomy to assure adequate treatment. Hysterectomy alone may be adequate therapy in limited disease, but cannot be considered adequate for all patients with varying degrees of tumor involvement.

Endocervical Involvement

Extension of endometrial carcinoma to the endocervix decreases the chances of survival. Of 25 patients in this series who had endocervical involvement, only 5 patients are living without evidence of cancer, regardless of therapy. The Annual Report³ lists survival figures of 30.6% in patients with fundal and endocervical involvement. Most authors^{1,7} now agree that such patients should be managed as though they have invasive cervical carcinoma.

When tumor involves the cervix and its lymphatic channels, simple hysterectomy is not adequate therapy; of 7 patients treated at this institution by preoperative irradiation and simple hysterectomy, only one is living. If the patient is not a candidate for a hysterectomy of the Wertheim type, which removes the paracervical and parametrial tissues, she should receive full irradiation therapy similar to that given for carcinoma of the cervix. Most vaginal cuff recurrences following simple hysterectomy for carcinoma of the endometrium will occur in patients who have either endocervical involvement or deep myometrial invasion.^{6,8} Of the 5 patients having such a recurrence following preoperative radium and hysterectomy, 4 had endocervical involvement and one had myometrial invasion. It would appear that the survival rate of patients with endocervical involvement might be increased by a wider use of radical hysterectomy.

Differentiation of the Tumor

Survival may be influenced by tumor differentiation. More differentiated tumors offer a better prognosis; less differentiated tumors tend to grow faster, invading the myometrium and involving the endocervix.^{2,4} Be-

cause of the increased virulence of the less differentiated tumors, patients with such tumors could be offered more extensive treatment.

The importance of finding squamous metaplasia in adenocarcinomas (adenoacanthoma) is unclear in this series. Such lesions have not been treated differently on this service, and the numbers treated are too small to draw conclusions regarding survival. Some authors⁶ suggest that adenoacanthomas are associated with a higher cuff recurrence rate; this finding was not confirmed in this series.

Prevention of Vaginal Cuff Recurrence

The possibility of vaginal cuff recurrence following simple hysterectomy for adenocarcinoma of the endometrium influences the choice of therapy; when simple hysterectomy is the sole method of treatment, most authors^{1,6} report a recurrence rate of 12% to 14%. Other series^{1,6} report a rate of only 1.5% to 3% in patients who received preoperative irradiation. The figures for the two groups in our series are 7.6% and 1.7% respectively.

Patients with vaginal cuff recurrences have little chance of survival. Of 6 patients with cuff recurrences after receiving primary therapy at Memorial Hospital, and of 11 patients referred with cuff recurrence, only 3 survived (18%). Treatment of cuff recurrences offers a poor chance of survival. Irradiation is usually technically difficult; exenterative survey is often impossible because of medical problems. Therefore, the emphasis must be placed on prevention of such recurrences.

Discussion

In view of these problems, how should carcinoma of the endometrium be managed? Gusberg¹ suggests the following treatment program:

Stage I—total hysterectomy with removal of the adnexal structures and a vaginal cuff.

Stage II—preoperative radium followed by hysterectomy (as above).

Stage III—preoperative radium and radical hysterectomy with node dissection.

Stage IV—exenteration.

Randall⁷ recommends the following treatment program:

Early cases: Patients with a short history, a normal-sized uterus, and no endocervical involvement are treated by total hysterectomy and bilateral salpingo-oophorectomy without previous radium.

Delayed cases: Patients with a long history of bleeding, an enlarged uterus, or endocervical involvement, receive preoperative radium followed by a radical hysterectomy, with or without node removal.

We agree generally with both of these programs, with one major exception: We prefer to use preoperative radium in all patients for two reasons: (1) a lower vaginal cuff recurrence rate; (2) elimination of the necessity for removing an extensive portion of the vaginal cuff. Price⁶ found no significant difference in vaginal cuff recurrences whether 2 cm or more of the cuff was removed or not. Wall⁹ pointed out that radium therapy lessens vaginal cuff recurrences and decreases the complications associated with ureteral mobilization, which must be done in order to remove adequately the upper vagina and paracervical tissues. It has not been our practice to remove a vaginal cuff, yet we would feel much more obligated to do so if preoperative radium were not used. If the uterus is of normal size, the colpostats of an Ernst applicator will deliver adequate dosages to the vaginal fornices and paracervical tissues, while the tandem will irradiate the primary tumor. In case of a larger uterus, and especially if surgery is not part of the therapy, intracavitary radium (Heyman capsules) should be used in addition to the Ernst applicator to deliver a higher dosage within the uterine cavity.

While radical surgery should probably be used more often, especially in patients with endocervical involvement, node dissection in conjunction with this surgery appears to be mainly of prognostic value. Randall⁷ noted no increased survival rate in 100 patients who underwent node dissection. Beck¹⁰ reported a 90% incidence of extrapelvic metastasis when pelvic nodes were positive.

Vaginal hysterectomy may have a place in the treatment of some patients with endometrial carcinoma. If the uterus is small and removal by the vaginal approach is practical, such management would be preferable to withholding surgery because of obesity or other medical problems. Pratt¹¹ reported excellent survival rates and low vaginal recurrences in 100 patients managed in this way (15% of his surgical series). An objection to this approach is the difficulty sometimes encountered in removing the adnexal structures, which are involved with tumor in approximately 11% of surgical patients.^{2,5} In our own series, no patient with a normal-sized uterus had ovarian or tubal metastasis.

Summary and Conclusions

A series of 174 patients treated between 1952 and 1965 is critically reviewed. Those factors which modify treatment and prognosis are discussed, and recommendations for management are made.

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available in Charlotte for blind children from that area. As of March, 1965, seven children having RLF were registered with the State Department of Public Instruction from the Charlotte-Mecklenburg school system. In addition to the students at the Governor Morehead School, there are 20 other children with RLF throughout the state, but most of the 20 have 20/200 vision in at least one eye. One of the latter group has since entered the Governor Morehead School and is included in this study.

In general the children with RLF have poorer vision than other children in the Governor Morehead School. One visual coding

been evaluated by an ophthalmologist. From an educational standpoint, "near vision" figures, as an indication of ability to utilize print materials, are of greater significance than formal distance acuity figures.

The range of birth weights of the children is outlined in Figure 3. The ages of the mothers are shown in Figure 4.

Psychologic Studies

All of the children were given selected psychologic tests, including the Wechsler Adult Intelligence Scale, the Wechsler Intelligence Scale for Children, and selected tests from a recent "HAPTIC" test devised for the adult blind. Digit symbol, object assembly, form completion, and a pattern form board were all utilized. Digit symbol consists of the tactile examination of shapes with superimposed raised dots, and identification of similar shapes (without raised dots) on another form board. The patient is then asked to tell the number of dots on the initial figure. The object assembly test consists of reassembling a doll or ball from which one part is missing. In another test, a patterned form is "shown" to the subject tactually and he reproduces the pattern on a nearby peg board. In addition to these tests, all subjects were rated by their home room teacher on a scale designed to obtain information about anxiety, space orientation, mannerisms, motivation toward physical independence, etc.

The average intelligence quotient of the children with RLF was 95.45, with a range of 62 to 133 (Figure 5). This is approxi-

Table 1
Visual Coding System¹

Vision Level	Visual Acuity or Designation
I	20/200
II	15/200 and 20/300
III	10/200, 20/4000, 15/3000, 20/500 & 10/500
IV	20/600, 10/300, 5/500, 5/200, 20/400, 20/800 & 10/500
V	4/400, 10/800, 5/800, 5/500, 2/200, 1/300 to 1/500, 20/1000 to 20/4000 & 2/400
VI	Counts fingers
VII	Hand movement
VIII	Light perception
IX	Totally blind

system in current use¹ is outlined in Table 1, and Table 2 summarizes the degree of defect in the children studied. From Table 2 it is also apparent that children with RLF have a greater degree of impairment than do most blind children in the United States as a whole. It should be recognized that visual acuity figures are often only an approximation, despite the fact that all children have

Table 2
Visual Levels of Governor Morehead School Children with RLF Compared with Other Blind Children in the United States

Vision Level	Governor Morehead School Children with RLF		American Printing House for the Blind* 1963		Residential Schools for the Blind* 1963	
	No.	Per Cent				
I	3	5	34		18	
II	1	2	5		4	
III	2	4	9		8	
IV	2	4	5		5	
V	2	4	1		2	
VI	4	7	6		9	
VII	1	2	3		5	
VIII	14	24	15		21	
IX	28	49	22		28	

*Figures represent percentage of total registrants.

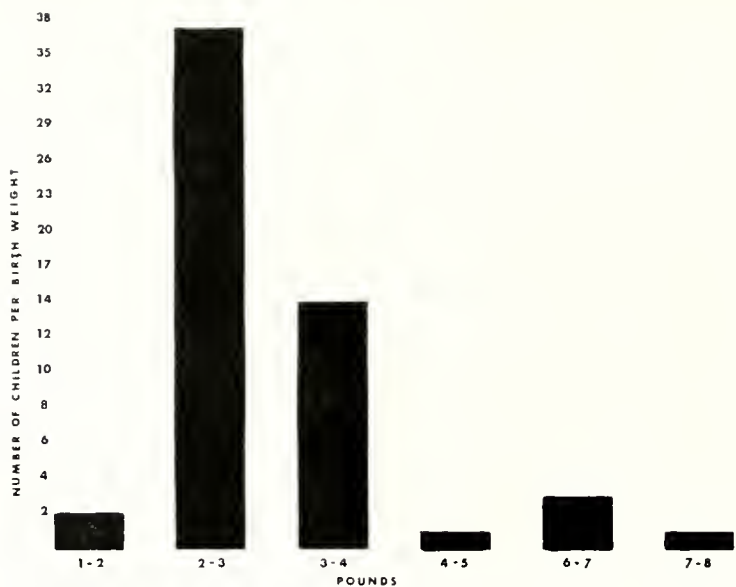


Fig. 3. Birth weights for children with RLF.

mately the same as the mean for the school as a whole. There was little difference in the verbal functioning of this group as compared to other blind children at the school. The children with RLF appeared somewhat lower in comprehension, concrete reasoning ability, and arithmetic reasoning; but they scored better in digit repetition and immediate recall. These differences, however, may reflect a difference in previous experience

rather than a difference in basic mental capacity.

Children with RLF often have limited opportunity to acquire motor knowledge and independent function due to the relatively high economic background and severe visual handicap of the group. Better comparative scores on immediate recall may be related to utilization of memory in this group.

In several children there appeared to be

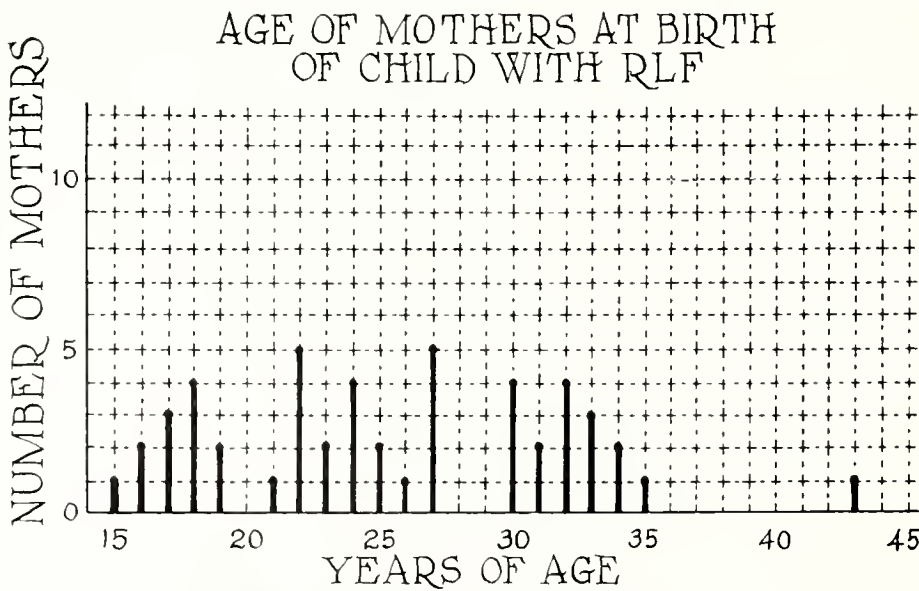


Fig. 4. Maternal age at birth of child with RLF.

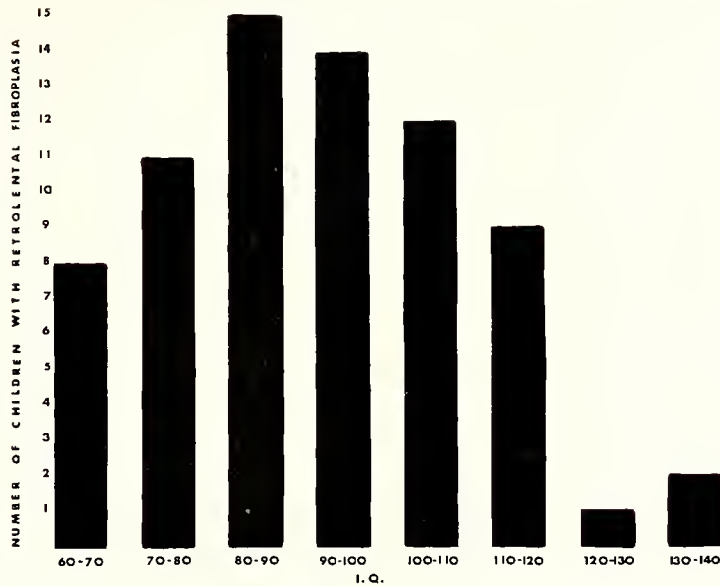


Fig. 5. Intelligence quotients of children with RLF.

mild developmental retardation, in that speech, crawling, walking, etc., had been slower than normal. Prematurity itself may partially account for this fact, but when walking is delayed beyond 4 years of age, other factors are probably responsible. In a few instances, speech development seemed normal, then stopped for long periods. Maturation may be genuinely slowed in some instances, but a major factor is the extreme environmental support some children with RLF have had in infancy. The child with RLF is often an only child, has had a difficult infancy, and may have economically secure parents, stunned by the problem of educating a totally blind child. It is particularly difficult to avoid overprotecting these children.

All the children manifested, at least while younger, the mannerisms often seen in blind children. These mannerisms consist of rocking from side to side, rapid finger or hand movements, and production of an auditory stimulus by a low hum or finger "popping." In addition, probably more than other blind children, almost all subjects "punched" their eyes. This very characteristic mannerism consists of light pressure exerted with the fingers, knuckles, or back of the hand against the orbital rim, lids, or eyebrows, and is likely to be performed during periods of concentration or boredom. Many of the other movements, particularly the rapid finger

movements, are more commonly seen when the student is excited. Many children have been observed to walk on tiptoes well into the school age.

All children were interviewed regarding their dreams, and about half related a meaningful dream history. All those with useful vision had predominantly visual dreams, often involving the day's residue of experience. None of the children who were totally blind from birth had visual dreams, and they usually had auditory, tactile, or motor experience during dreams. Nightmares in the sightless group consisted largely of sensations of bodily injury, never of running to escape and the like.

Neurologic Status and Electroencephalography

Most of the children were neurologically normal. One child has had seizures, and 6 had unequivocally abnormal neurologic test results. The abnormalities were usually minor, however, and no child had marked hemiparesis, tremor, athetoid movements, or cranial nerve deficit other than those related to the visual system. None of the children without vision were able to direct their eyes on command, and the incessant random nystagmus of the blind characterized the entire group. Even in children with extreme microphthalmia and a barely discernible cornea,

Table 3

Resident Live Birth Rates Per 1000 Population
in North Carolina by Color
(1944-1964)*

Year	Total	White	Nonwhite
1944	25.2	24.3	27.6
1946	27.7	27.3	28.6
1948	28.8	27.4	32.3
1950	26.2	23.5	33.6
1952	26.7	24.1	34.0
1954	26.9	24.3	34.4
1956	26.6	24.0	34.2
1958	24.8	22.5	31.6
1960	24.1	22.1	29.8
1962	23.5	21.6	29.2
1964	22.3	20.2	28.3

*Data obtained from the National Office of Vital Statistics, Washington, D. C.

there was exquisite sensation to light touch of the orbital contents.

In agreement with the findings of others,⁴ EEGs in 13 of our patients were abnormal. These abnormalities were all confirmed on repeat testing. All the abnormalities were found in children with almost total lack of useful vision. As is emphasized in the literature, there was, with the exception of the one child who had seizures, no correlation between the presence of an abnormal EEG and neurologic deficit. Similarly, there was no correlation between the IQ level and the EEG. The EEGs of several children contained abortive spike and dome complexes, which were poorly differentiated. Slow waves, at less than 5 cycles per second, were seen in all the abnormal tracings. In addition, and of particular theoretical interest (see Discussion), unequivocal spike discharges were present in the occipital regions of 6 children. None of these children had seizures.

Discussion

Although RLF may be assumed to be decreasing, it has not disappeared in the 15 or more years since its association with treatment of premature infants with high levels of oxygen was discovered. A review of the available early infancy records of these children tends to confirm the impression that when oxygen was used, the physician considered it essential in order to save the life of the babies, but recent literature questions the need for any oxygen unless the child is cyanotic. The relative rarity of RLF in the Negro

Table 4

Resident Premature Live Births* in North Carolina
by Color (1952-1964)**

Year	Total	White	Nonwhite
1952	1,363	821	542
1954	1,321	762	559
1956	1,489	848	641
1958	1,506	876	630
1960	1,385	757	628
1962	1,539	852	687
1964	1,497	759	738

*Birth weights less than 3 pounds 5 ounces.

**Data obtained from the Public Health Statistics Section, North Carolina Department of Public Health, Raleigh, N. C.

in North Carolina is probably related to differences in management of the prematures, since the relative mortality rates do not explain the differences in incidence between white and Negro (Tables 3-6).

As pointed out by Terry,¹ RLF may occur in 10% of infants weighing 3 to 4 pounds at birth. Several children in the Governor Morehead School weighed less than 2 pounds at birth, and only 5 weight over 4 pounds. In view of the increased survival rate of extremely small premature infants, and the fact that preschool children with RLF are still seen, it seems unlikely that the condition will completely disappear from North Carolina.

The children in the Governor Morehead School are an educable group, and therefore it is not surprising that neurologic abnormalities and extreme emotional illness are less apparent in this group than in other reported series.

There is a high incidence of what has been called childhood autism in RLF, with prominent stereotyped movements, toe-walking, and extreme attachments to objects in childhood (particularly noise-makers). These peculiarities have prompted a diagnosis of childhood schizophrenia in such children,⁵ but this diagnosis does not seem warranted in any of our children.

Mannerisms, stereotyped movements or mannerisms (sometimes called "stereotypies" or "blindisms" by educators that work with the blind) are not peculiar to the blind, of course, and are seen in some normal children, in mental defectives, and in primates who have been maintained in social isolation. The reason for the mannerisms is uncertain. The

Table 5

Neonatal* Death Rates Per 1000 Live Births in North Carolina by Color (1944-1964)**

Year	Total	White	Nonwhite
1944	25.4	23.1	30.5
1946	24.9	23.7	27.8
1948	23.0	20.7	28.0
1950	21.4	18.6	26.7
1952	22.0	18.7	28.6
1954	19.4	15.8	26.6
1956	20.4	17.2	26.7
1958	21.1	18.4	26.6
1960	20.2	16.5	28.2
1962	19.7	16.7	26.4
1964	19.9	16.1	28.0

*Birth—27 days.

**Data for 1944-1962 obtained from the National Vital Statistics Division, U. S. Public Health Service, Washington, D. C.

Data for 1962 obtained from the Public Health Statistics Section, North Carolina State Board of Health, Raleigh, N. C.

movements are vigorously interdicted at the school, as part of the general effort to achieve a normal posture, gait, and facial expression.

Significant psychologic differences between these children and other blind children are difficult to substantiate, although most workers suspect that such differences exist. There appears to be a greater persistence of mannerisms or "blindisms" in this group, and there may be a greater tendency to indulge in day dreams and fantasy. As a group, the children have some difficulty in learning to use their hands effectively. None of these features is peculiar to these children, however, and numerous exceptions have been noted.

The essentially normal results of neurologic examinations are in contrast to the report by Bender,³ which suggests that almost all children with RLF are brain damaged. Since Bender's group of children were in the Creedmore State Hospital and ours are active in school, the difference is not surprising.

The abnormal EEGs in our group are not easy to explain. This finding has been observed previously by several others.⁶ Prematurity and factors leading to prematurity may have produced some diffuse brain damage, even though such damage was not manifested in seizures, mental deficiency, or ab-

Table 6

Infant* Death Rates Per 1000 Live Births in North Carolina by Color (1944-1964)**

Year	Total	White	Nonwhite
1944	45.4	38.8	60.0
1946	37.2	32.7	47.9
1948	35.3	29.5	47.6
1950	34.5	26.7	49.7
1952	35.7	26.4	54.0
1954	30.2	22.1	46.5
1956	30.9	22.9	47.2
1958	32.6	24.5	49.2
1960	31.7	22.3	52.4
1962	30.5	22.2	48.7
1964	30.2	21.5	49.0

*Birth—27 days

**Data for 1944-1962 obtained from the National Office of Vital Statistics, Washington, D. C.

Data for 1964 obtained from the Public Health Statistics Section, North Carolina State Board of Health, Raleigh, N. C.

normal results of neurologic examinations. A second and theoretically more interesting explanation is that the abnormal EEG activity occurs secondary to isolation of an area of the cortex from its peripheral input. Denervated neural tissue and isolated cortical slabs are prone to develop abnormal discharges.⁷ Neurons in the occipital cortex of cats which have been blinded from birth are reported to be abnormal neurophysiologically.⁸

Summary

Retrolental fibroplasia is the apparent cause of blindness in 58 out of 396 of the students at the Governor Morehead School. A few children with this disorder are still seen each year as new students. There is little evidence of neurologic abnormality in our children, although 13 of the 58 have had abnormal electroencephalograms on two or more occasions. These children display a high frequency of stereotyped hand and body movements.

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Psychologic Characteristics of Children with Cystic Fibrosis

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DURHAM

Cystic fibrosis (CF) is one of the most common chronic diseases seen in pediatrics today, and although in recent years the prognosis has improved, it remains a frequently fatal disease. The management of patients with this disease is a trying experience for the patient's family as well as the physician, since the diagnosis frequently gives rise to severe emotional reactions in the patient, parents, and family, especially the most deep-seated anxiety of all—fear of separation and death.

Although some excellent behavioral studies have been conducted with regard to chronic and fatal diseases such as leukemia^{1,2} and muscular dystrophy,^{3,4} little attention has been focused on the psychologic aspects of cystic fibrosis.⁵

It would seem useful to inspect the psychologic variables surrounding this condition in order to improve our understanding and management. It would also seem important to investigate the effects of parental feedback on the behavior of the child. Interest in the latter has increased with the reports by medical staff members, educators, and others that the children seen in the Cystic Fibrosis Clinic of Duke Hospital seem intellectually brighter, more articulate, and more socially adept than the average child. The persistence of these reports led us to investigate their validity.

A pilot study was undertaken in order (1)

to sample the intellectual levels of the patients with CF, and (2) to evaluate the social and psychologic aspects of these children's behavior patterns.

Material and Method

Thirty-four children ranging in age from 3 to 16 years were randomly picked from the CF Clinic at Duke University Medical Center. During the course of the study one child died, and seven moved from the geographic area or withdrew from the clinic. Five could not complete the evaluation for assorted reasons.

Each of the 21 children (13 girls, 8 boys) undergoing the complete evaluation was administered the Peabody Picture Vocabulary Test (Form A), the Goodenough Draw-a-Person Test, and cards A, 3, 4, and 6 of the Bender Visual Motor Test. The last was administered first as an "ice-breaker."

Each child was seen individually in the psychologic testing area of the Pediatric Outpatient Clinic after a routine clinic visit for medical or physiotherapeutic treatment. The mean age of the group evaluated was 8 years 6 months. Three-fourths of the group were rated good or excellent on the Shwachman Scale for evaluation of the clinical condition of patients with CF. The intelligence test scores were analyzed to determine the mean IQ of the group. Figure drawings were evaluated for inference concerning psychologic factors.⁶

Results

The IQs of the 21 subjects ranged from 81

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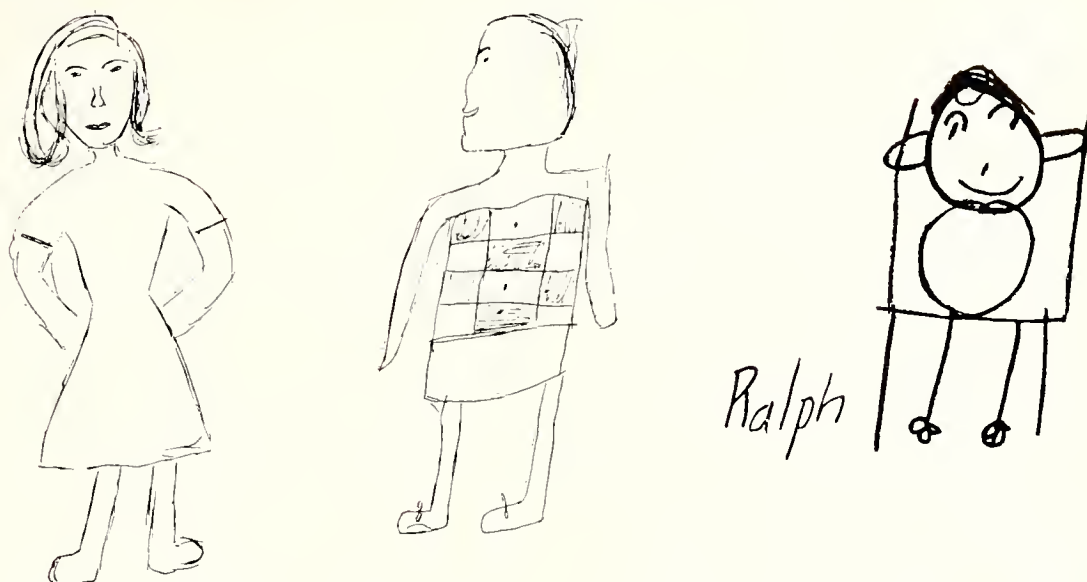


Fig. 1. Sample drawings of children with cystic fibrosis. Note emphasis on hair and eyes and de-emphasis of hands in drawings at left (A), and emphasis on the chest in drawings at center and left (B, C).

to 150, with a mean of 104 (Table 1). This mean score is slightly higher than average but not significantly different from the mean IQ of 100 with the size sample of subjects. Distribution by sex indicated a mean IQ of 103 for the boys and 105 for the girls. Neither mean score is significantly different from the mean IQ of 100 for this sample.

Table 1

Intelligence Quotients of Children with Retrolental Fibroplasia by Sex

	No. Subjects	Mean Score	Range
Male	8	103	81-144
Female	13	105	86-150
Total	21	104	81-150

Of interest with regard to the Picture Vocabulary Test was a generally greater than "normal" span of "scatter" in the error responses on the intelligence tests. This "scatter" has been considered by some clinicians⁷ to be indicative of the presence of a high level of anxiety.

Inspection of the drawings (Fig. 1) indicates emphasis on the eyes, seeing, and being seen. In addition, there is emphasis on the hair, thought to indicate both a high level of anxiety and a need for strength.⁸ There was also notable de-emphasis of the hands, especially among the girls, which is said to indicate feelings of inadequacy and a need for

support. In five drawings (Fig. 1 B-C) the chest appeared oversized for the rest of the torso. This is a common finding among drawings of tuberculosis patients.

Also of interest were the off-hand remarks of some of the subjects in the act of drawing the human figures. For example, one very bright 16-year-old girl commented, "She's maldeveloped; I'll tell you that!" It is of interest that the appearance of secondary sexual characteristics was delayed in this patient.

Discussion and Conclusions

Psychologic evaluation indicated that among 21 children having cystic fibrosis there was an average mean intelligence. This is contrary to our hypothesis that the mean IQ of the patients with cystic fibrosis would be significantly higher than the average IQ of 100.

In general, it appears that children with this disease tend to become more highly verbal in response to their own anxiety, and perhaps also to that of their parents. This characteristic makes them seem brighter than the general population. The increased anxiety of these children is reflected in the figure drawings as well as the anxious verbal output observed during interviews. It takes the form of politeness, neatness, and

social conformity, which are often equated with intelligence in our culture.

In addition, it is postulated that the heightened sympathy and overprotectiveness of the parents, who are aware of the fatal outcome of the disorder and are attempting to control their anxiety, creates consistent positive reward schedules. As a result, the children distort their reality into a world that is almost "too good to be true." It is probable also that the parents increase their tolerance of noxious behavior on the part of children with terminal disorders, so that a maximally permissive atmosphere exists in the home. The net result of this permissive and extremely anxious family atmosphere appears to be a "pseudo-superintellectual" child.

A comparison of this group of patients with other chronically ill children would seem in order, as well as a greater in-depth evaluation of the personality structures of the older patient with cystic fibrosis and his influence on the family setting.

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Agriculture, the first and most healthful of employments, is now followed by few who are able to carry on any other business. . . . Though sedentary employments are necessary, yet there seems to be no reason why any person should be confined for life to these alone. . . . It is constant confinement that ruins the health. A man will not hurt by sitting five or six hours a day; but if he is obliged to sit ten or twelve he will soon become diseased.—William Buchan: *Domestic Medicine, or a Treatise on the Prevention and Cure of Diseases by Regimen and Simple Medicine*, etc. Philadelphia, Richard Folwell, 1799, p. 52.

Wegener's Granulomatosis

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Wegener's granulomatosis is an uncommon but devastating disease which involves multiple organ systems and produces a great variety of symptoms and signs in the affected patient. Because of this, the correct diagnosis is often not made until the patient's condition is terminal and therapy is ineffective. A patient seen recently at North Carolina Memorial Hospital illustrates many of the classic features of the disorder and is presented here with a brief review of pertinent literature and suggestions for early definitive diagnosis.

Clinical Case History

The patient, a 51-year-old white man, first consulted his physician on June 23, 1965, approximately three months before death, because of cough and fever. He had apparently had intermittent nasal congestion since the previous winter but had been able to continue his work in a lumber yard until late June. He was treated initially with antibiotics but failed to improve and was hospitalized on July 8 following the onset of hemoptysis. Despite treatment with several different antibiotics during the first week of hospitalization, he remained febrile and continued to cough up bloody, purulent sputum.

On July 16, he was transferred to another hospital, where he remained for about one month. There, he was intermittently febrile, with temperatures as high as 105° F., and continued to cough up bloody, purulent sputum containing variable bacterial flora. At one point a small ulcer was observed on his epiglottis. Thrombophlebitis developed in his right leg but subsequently resolved. Repeated chest x-rays showed variably distributed pulmonary infiltrates which at one time or another involved each of the five major pulmonary lobes. Multiple studies did not lead to a definitive diagnosis, and the patient

was treated with several different antibiotics without apparent improvement. On a regimen of prednisone he improved initially but then began to worsen again. While in the second hospital his urinalyses showed varying degrees of albuminuria and microscopic hematuria and pyuria. The level of blood urea nitrogen (BUN) there was normal. On August 15, 35 days before death, he was transferred to North Carolina Memorial Hospital.

Admission examination here revealed a thin, chronically ill white man with pulse 120/min, respirations 32/min, blood pressure 112/78 mm Hg, and temperature 99.6 F. He had lost approximately 30 pounds since the onset of illness. There were irregular rales, areas of dullness, and decreased breath sounds over both lung fields. Initial chest films showed irregular infiltrates in both lung fields, and initial laboratory studies disclosed a hematocrit level of 30%, a white blood cell count of 13,300/cu mm (predominantly polymorphonuclear leukocytes), blood urea nitrogen 26 mg/100 ml, serum albumin 1.6 gm/100 ml, and serum globulin 5.3 gm/100 ml. Urinalysis revealed 1 plus albumin, 5-10 white blood cells per high power field, and scattered hyaline, white blood cell, and granular casts.

The patient was treated with Ampicillin for the first ten days, during which the dose of prednisone was tapered and eventually discontinued. Several different species of bacteria were cultured from the sputum, and after the first ten days he was placed on a regimen of Keflin. He remained intermittently febrile, became progressively weaker, and showed no persistent improvement at any time. Multiple studies again failed to lead to a definitive diagnosis. Despite numerous transfusions, his hematocrit remained just below 30%. Terminally the BUN was 155 mg/100 ml, and the patient was in extreme respiratory distress. He expired on September 21, 1965, about three months after first consulting his physician.

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Fig. 1 (x 65). This portion of the inferior laryngeal wall exhibits a mucosal ulcer and underlying granulomatous inflammation.

Autopsy Findings

Many small visceral arteries exhibited foci of acute mural inflammation and fibrinoid necrosis. These included numerous pulmonary arterial branches in both lungs, many trabecular and follicular arteries and arterioles in the spleen, multiple small hepatic and renal arterial branches, several peria-adrenal arteries, and a few branches of the coronary, testicular, prostatic, and intestinal arteries. In all these foci, the arteritis was generally characterized by fibrinoid mural necrosis, neutrophilic infiltration, and irregular epithelioid cell proliferation. A few eosinophils were present in some of the foci. Many of the inflamed arteries contained thrombi of varying ages, and there were corresponding infarcts in the lungs, spleen, liver, adrenals, and kidneys.

The larynx, trachea, and bronchi in both lungs exhibited extensive acute and chronic mucosal inflammation and multiple sites of ulceration (Fig. 1). There were numerous granulomatous foci in the laminae propriae of all these structures.

The lungs weighed 1970 gm combined. Extensive fibrous and fibrinous adhesions were present in both pleural cavities. Both lungs contained multiple irregular, firm, confluent granulomas, many foci of acute arteritis, numerous arterial thrombi, and a number of old and recent infarcts (Fig. 2). A few multinucleated giant cells were present in some of the granulomas; however, giant cells were not a prominent feature of these lesions

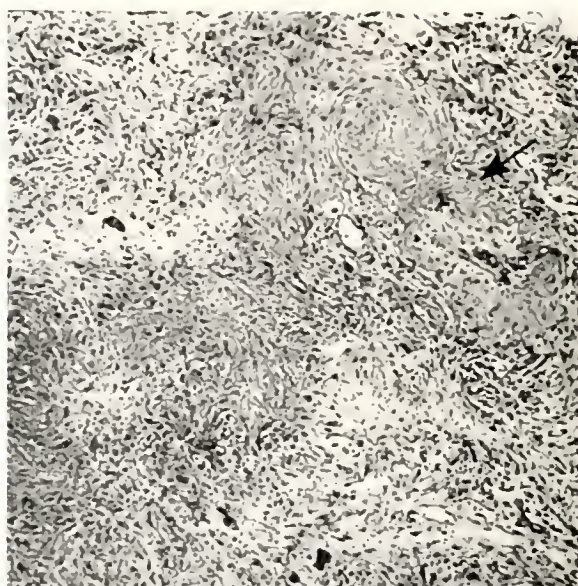


Fig. 2 (x 80). This photomicrograph from one of the pulmonary lesions illustrates confluent granulomas and several giant cells. The small pulmonary arterial branch (arrow) is acutely inflamed and exhibits fibrinoid mural necrosis.

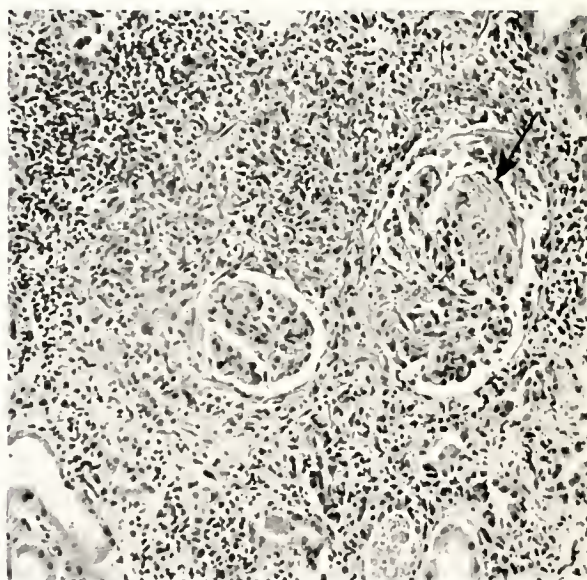


Fig. 3 (x 130). A granuloma has developed around these two glomeruli. The larger glomerular section exhibits focal fibrinoid change in a capillary tuft (arrow).

nor of the granulomatous foci elsewhere. At the apex of the left upper lobe, there was an irregular cavity measuring 3.5 cm. in its greatest dimension, the wall of which was composed largely of granulation tissue lined internally by a layer of fibrin and necrotic debris.

Around the heart there was fibrinous pericarditis, and the coronary arteries contained several foci of acute arteritis.

The spleen weighed 300 gm and contained multiple foci of acute trabeculitis and arteritis, numerous small granulomas, generally centered upon inflamed follicular arterioles, and a single recent infarct measuring 1.5 x 1.0 cm.

In the liver, acute necrotizing vasculitis involved branches of the portal vein as well as of the hepatic artery. In the right lobe, there was an irregular infarct measuring 1.0 cm. in its greatest dimension.

Both kidneys contained multiple foci of acute arteritis and a number of recent infarcts. Extensive acute and chronic inflammation involved the interstitium and many glomeruli. There were numerous small granulomatous foci, some of which were centered upon inflamed arteries or glomeruli (Fig. 3).

Discussion

The first recognized case of Wegener's granulomatosis was described by Klinge¹ in 1931. In 1936, and again in 1939, Wegener described several additional cases and further characterized the entity which now bears his name.

Godman and Churg² have defined the essential pathologic features as follows:

1. Necrotizing granulomatous lesions in the upper air passages, the lower respiratory tract, or both.
2. Generalized focal necrotizing vasculitis, which may involve both arteries and veins.
3. Glomerulitis, with evolution of many of the glomerular lesions as granulomata.

According to Walton,³ the essential diagnostic features are:

1. Giant cell granulomatous ulceration at one or more levels in the respiratory tract.
2. Widespread giant cell granulomas, most frequently in the lungs, the kidneys, and the spleen.
3. Generalized necrotizing lesions of small vessels, again most common in the lungs, kidneys, and spleen.

The disorder occurs most frequently in individuals in the fourth and fifth decades of life.^{1, 3} The earliest signs and symptoms are usually referable to the respiratory tract^{1, 3} and include those of sinusitis, nasopharyngitis, focal stomatitis or laryngitis, tracheobronchitis, and pneumonia. These are soon followed by development of widespread vasculitis and glomerulitis,^{1, 3} with microscopic hematuria and pyuria, azotemia, and eventually, uremia. The disorder is usually rapidly fatal, and the average duration in untreated cases is from five to six months.^{1, 3} In one series,² renal lesions were directly responsible for the fatal issue in 86% of the cases. Several authors have reported remissions and prolonged courses following treatment with steroids.⁴ The etiology is undetermined; however, authors who have studied a number of cases generally regard it as a hypersensitivity disorder.^{1, 3, 4, 5}

Pathologically, our case satisfies both sets of diagnostic criteria outlined above. The age of onset, the duration, and the clinical course are typical, and it would seem that both respiratory and renal insufficiency played significant roles in the patient's death. Transient improvement was reported with steroid therapy; however, this did not persist, and this treatment was subsequently discontinued. It is possible that superimposed respiratory infection diminished the effectiveness of steroid therapy in our case.

Although a few multinucleated giant cells were present in many of the granulomas in our case, these cells were not nearly so numerous nor so prominent as they have been in some other reported cases.^{1, 3}

Hyperglobulinemia was an outstanding feature of our patient's illness. This has been seen in a number of other reported cases, and in Walton's series,³ 80% of the patients whose serum proteins were studied had elevated globulin levels.

Early definitive diagnosis in many cases, as in ours, has been difficult. Since this is an uncommon disorder, the diagnosis may not be considered initially, or if it is, it may seem difficult to differentiate from other conditions which produce a similar clinical picture. Biopsy of the mucosal lesions in the

upper respiratory tract has been useful,^{1, 4, 5} and should be attempted if this diagnosis is considered. Tracheal⁴, bronchial¹, or even lung biopsy^{1, 2} may prove valuable if the primary site of respiratory involvement is in the lower respiratory tract. Renal biopsy has also been helpful in some cases, although it may not be possible to differentiate the renal changes from those of other vasculitides or collagen diseases if granulomas are not included in the biopsy specimen.^{4, 5}

Summary

A case of Wegener's granulomatosis is reported. The clinical and pathologic features are described and compared with those of other cases reported in the literature. Sug-

gestions are given for early definitive diagnosis by biopsy of involved sites.

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The Role of the Physician as a Sex Counselor

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NEW YORK

North Carolina physicians should be grateful for the impetus being given by the Bowman Gray School of Medicine to the movement to have physicians assume their proper roles as leaders in sex education and sex counseling. To those of us involved in the movement toward enlightened sex education, the most dramatic development of recent years is the changing attitudes of medical schools. Just a few years ago not more than two medical schools in the nation offered any instruction about problems of sex in their general curriculum. At last count the number had increased to 30. It is encouraging, too, to see the *JAMA* and other journals whose pages for so many years were silent on problems of sex devote increasing attention to the subject.

We would be remiss, however, if we did not recognize that these advances are just a very belated beginning, and that most doctors—in all branches of medicine except perhaps psychiatry—are still not giving sufficient guidance to their patients in this important aspect of their lives, and have not devoted themselves to acquiring the attitudes,

the skills, and the knowledge to be effective counselors. In this, of course, they have merely paralleled the attitudes of teachers, parents, ministers, and other groups in our society.

But the physician bears a heavier responsibility. Ethel Nash¹ of Bowman Gray, in a recent article in *Consultant*, remarks that he is a marriage counselor in spite of himself. This is equally true in the field of sex. Whether he likes it or not, the physician is always offering sex counseling, and his very silence may have an important effect. This silence may indeed sometimes pronounce a death sentence on the effective sex functioning of a patient.

Recent Failures to Provide Guidance

Let me cite several recent examples of lack of guidance on the part of physicians. At the 1964 convention of the American College of Cardiology, a disquieting report was given by three cardiologists.² These physicians had just questioned a number of men who had had heart attacks about their sexual activity after the attacks. Two thirds of the patients were under the age of 50, and their heart attacks had occurred from one to nine years before the interviews.

The physicians found that only about a third of these men had resumed their normal

Remarks made at a breakfast held by the Committee on Marriage Counseling, Medical Society of the State of North Carolina, Asheville, May 3, 1966.

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pattern of sexual activity. The other two thirds had experienced a marked and lasting reduction in the frequency of intercourse, and 10% had become completely impotent.

The most significant aspect of these responses is this: The pattern of sexual activity following the heart attack bore no relation either to the age of the men or to the severity of the attack. It depended almost entirely on the attitudes of the men involved. Virtually none of the men had received from his physician any detailed and specific advice about sexual activity. As a result, each patient had to make his own decisions. One third of the men reported that they had received only vague advice about sexual intercourse. The other two thirds had received no guidance at all from their physicians.

Let me give you a more personal example. Recently, the wife of one of our colleagues had to go to the hospital for a dilatation and curettage. I suggested that the wife ask the physician when she might resume intercourse. She reported that he had seemed quite taken back at this question, stammered a bit, and then replied, "In three weeks after the operation."

At this point I decided to put the question to Dr. LeMon Clark, the medical adviser of *Sexology* and a practicing gynecologist. Here is his reply:

I called one of my younger confreres here, who just finished his residency a year ago, and asked him what the present day teaching was on abstinence from intercourse following a D and C. He said that they were told two weeks, but he thought one week was undoubtedly long enough. I have always told my own patients four or five days—just long enough to give the cervix a chance to come back down to where the mucus plug will fill it.³

The difference between four or five days of abstinence and three weeks is, I submit, considerable.

Here is a further example. Several months ago, a woman called me in agitation from Washington (my office is in New York). Her husband, a man of 60, had learned that he had to undergo prostatic surgery for possible carcinoma and had been told by the surgeon that he had to sign a statement ac-

knowledging the possibility that he would be impotent following the operation. Since this was at variance with some of the research about the effect of prostatectomy reported in my book, *Sexual Life After Sixty*,⁴ she wanted to know whether this surgeon's prognosis was correct. Since I am not a medical doctor, I referred her to a urologist in whom I had confidence.

I do not know the final outcome of this particular case, but Finkle and Prian⁵ mentioned a similar situation in their article, "Sexual Potency in Elderly Men Before and After Prostatectomy." They discussed the many psychologic reasons why men often end their sex activity after prostatectomy, and told of a patient who underwent radical perineal prostatectomy for carcinoma at 49 years of age. Their report reads as follows:

... He was given every encouragement as to the likelihood of preservation of sexual potency. During rather frequent visits in the first six months post-operatively, the patient reported failure in occasional efforts at intercourse with his cooperative, sympathetic wife. After six months, he began to visit a local urologist periodically, since the trip to San Francisco was time-consuming. That urologist promptly told him that all people are permanently impotent after perineal prostatectomy. The crestfallen patient and his wife denounced the original urologist for having deceived them as to the possibility of preserving potency. **Perhaps the comment by the new urologist that impotency was inevitable contributed to the impotency**, because it is reported that 10% of patients retain potency after radical perineal prostatectomy, including men generally older than this patient.

These authors then go on to discuss problems of aging.

Much myth and ignorance revolve about the sexual interest and competency of older people. We have found this to be true both for patients and their physician-advisors . . . Indifference or neglect by the physician in frank discussion of sexual potency may suppress any likelihood of continuation of sexual activity in the aging patient.

The bright side of all of this is that the criticism is coming increasingly from within the medical profession itself. I am convinced that once physicians have raised these problems sharply enough with themselves, the changes will not be too long in coming.

Conflicting Views of the Physician's Role

I am not suggesting that there will be any simple or easy way for doctors to handle the sexual problems of their patients. As Dr. William F. Sheeley noted in an excellent article in the *JAMA*:

Sexual feelings and activities, whether normal or disordered, are the final common pathway of a complex constellation of numerous and various influences and conditions. (They) certainly have roots in physiological function. But they also have roots deep within the psychological being of the individual and within his interpersonal adjustments with other people . . . People use the promise, the giving, and the withholding of sex to bribe, dominate, cajole, disarm, mollify, ward off, frustrate, reward, mislead, reassure, exploit, and comfort others.⁶

Dr. Sheeley goes on to make an extremely important point. "No society," he says, "has solved the problem of providing on the one hand, great sexual freedom for its members and, on the other, adequate safeguards to protect and care for the children which issue from sexual activity and upon which the society's continued existence depends." And, he concludes, "In the end, each person must solve for himself the problem of meeting the demands both of society and of his own nature. The solution is not easy." And he warns the physician against adopting "a posture which is either too strict or too lax morally—or too different in quality from the patient's own moral code—for the patient to accept it."

Unfortunately, not all those who counsel the physician possess the breadth of vision and the wisdom shown by Dr. Sheeley. Too many persons see the role of the physician as that of the special pleader for traditional morality, disregarding the findings of research and rigidly defending the most conservative moral point of view.

Such a paper was a special article in the *New England Journal of Medicine*, "The Physician and the Sexual Revolution," by Dr. Max Levin, a clinical professor of neurology.⁷ This paper, which received considerable publicity, was not welcomed with unanimous enthusiasm by readers of the *Journal*. One letter to the editor, from a physician in Kentucky, was very brief:

I enjoyed Dr. Levin's sermon. However, since it was obviously delivered to the Society for the Suppression of Vice sometime in the 1890s, why did you wait so long to publish it?⁸

I cite Dr. Levin's article because it represents a common trend in medical thinking: the belief that the physician must take over a role which ministers are no longer able to perform effectively.

The Sex Information and Education Council of the U. S. (SIECUS), of which I am an officer, also faces such attitudes. When our organization was first reported editorially in *Medical Tribune*, Dr. Goodrich C. Schauffler, a well-known medical author of Portland, Oregon, wrote a lengthy letter to the editor asking SIECUS to take on the job of defending traditional morality against "the false prophets" and the "prosexual propagandists."⁹ Our executive secretary, Dr. Mary S. Calderone, replied that we did not view our function as that of trying "to impose conformity in or to a set of standards of human behavior, but rather to stimulate questioning about old, and questing for new, basic knowledge in a given field and then to open up that knowledge for exchange, discussion, and individual decision by as many social groups as possible."

In other words, we are trying to create an atmosphere which will provide as much knowledge, information, and insight to each individual as possible, so that he can reach moral as well as other decisions as wisely and intelligently and with as much insight as he possibly can. This type of approach, we feel, is particularly important in dealing with the adolescent, which was my field of specialization in working for a doctoral degree. I am firmly convinced from whatever dealings I have had with the adolescent, as well as any theoretical reading I have done, that to try to approach sophisticated young people with the unsophisticated type of sermon that Dr. Levin preaches would be a complete waste of time and would cut us off from the possibility of any real dialogue with most youth. Without this dialogue, we can have no possible educational effect.

How can we possibly go to young people today and try to convince them that we adults have all the answers to questions of

sexual morality, or that we have ordered our sex lives and practices so well that they cannot be happy unless they follow in our footsteps?

Youth's Search for a New Morality

Here's what a 17-year-old high school junior replied to advice of this kind in a recent conference of parents and clergymen in a New York suburban church: "I know your code of sexual morality, and I say there must be a better way—that's what I'm trying to find. I'm leaving the moral road you're on, and in leaving it I can see it more clearly than you can."¹¹

It would be a great mistake, I think, for us to dismiss this youngster's protest as part of a great process of moral degeneration taking place among youth, as many of us tend to do. Much of it—by no means all—is an honest attempt to find a new morality. In many cases, young people are doing openly what we do covertly; or doing honestly what we do hypocritically. Supreme Court Justice William O. Douglas has suggested that youth, like the opposition party in a parliamentary system, has served a powerful role: "It has cast doubts on our policies, challenged our inarticulate major premises, put the light on our prejudices, and exposed our inconsistencies. Youth has made each generation indulge in self-examination."¹²

I think that nowhere is this self-examination by adults so necessary as in the area of sexuality. And unless we are really honest and really critical, we will lose our opportunity to have a dialogue with youth and influence them in the direction of responsible sexuality.

I am convinced that the beginning of wisdom is the recognition that the old absolutes are gone, and that we have entered a period of great national debate where many of our old values and moral beliefs—once thought sacrosanct and closed to any kind of challenge—are now being questioned. Instead of one set of moral absolutes, we now have a series of sharply conflicting moral philosophies that are competing especially for the minds of our youth.

In a recent article on sex education, Dr.

Arthur H. Steinhaus, Dean Emeritus of George Williams College in Chicago, gave this advice: "The wisdom of chastity and all that it implies need not be considered a debatable subject."¹³

With all respect to Dr. Steinhaus, to my simple mind a debatable subject is one about which sharp difference of opinion exists. If a subject is actually being debated, we cannot make it nondebatable by pretending the debate doesn't exist. If the question of chastity is not a debatable subject among college youth today—as well as among all professionals in the family life field—then what on earth is? What else is debated endlessly in college dormitories? What else is discussed endlessly in the columns of *Playboy* (bought by more than 3-1/2 million young persons every month)?

Lest we think that this debate goes on only among young people or irresponsible adults, let me quote what Dr. Jessie Bernard, distinguished research scholar, had to say about changes in thinking which had taken place in the highly conservative and highly responsible National Council on Family Relations. In an address to the Council's annual meeting in 1963 she said: "There was a time when those arguing for premarital virginity could be assured of a comfortable margin of support in the group. This is no longer always true. Especially the younger members no longer accept this code."¹⁴

Thus, whether we like it or not—and I for one do not—we do not today possess a sexual code on which we can agree. Today, for the first time in our history as a nation, the individual is confronted with an array of competing value systems of sex, and for the first time in our history he is granted a relative amount of freedom to make a personal choice.

Until now, sex educators—and I include parents, ministers, and public figures of many types in this category — have spent their time trying to impose unquestioned acceptance of the old absolutes. Today, they must begin to educate in the best sense of the term.

Competing Value Systems

I have found it useful to identify six conflicting value systems along a broad contin-

uum ranging from extreme asceticism to a completely permissive anarchy. Since I have analyzed them at greater length elsewhere,¹⁵ I will merely touch upon them here.

These value systems are: (1) *traditional repressive asceticism*—a rigid, dogmatic, intolerant position, which is still embodied in most of our codes and official pronouncements; (2) *enlightened asceticism*, which is neither dogmatic nor unquestioning, but does basically accept the tenets of traditional morality; (3) *humanistic liberalism*, which opposes the laying down of absolutes and sets up as the criterion of morality, not the commission of a certain act, but the consequences of the behavior on interpersonal relationships; (4) *humanistic radicalism*, which goes further, to set as its goal the attainment of far greater freedom in sex; (5) *fun morality*, which holds that sex is fun, that the more sex the better, and that sex becomes immoral only when it involves the deliberate harm of one person by another; and (6) *sexual anarchy*, which advocates complete sexual freedom and calls for the suppression of all anti-sexual taboos.

I believe that, in one way or another, these value systems are competing for the minds of our youth, and that the major task of any community's leader is to play his proper role in analyzing, according to his own field of specialization, the positive and negative aspects of each one of these philosophies.

If our young people are going to have to choose, let us help them choose wisely, with

the fullest possible knowledge of whatever research results we have or facts we know, with the deepest possible insight into their own ego-needs and personal moral codes, and with the broadest possible acceptance of social responsibility.

As physicians, you can play an important role in each of these complex areas.

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... every person who follows a sedentary employment should cultivate a piece of ground with his own hands. This he might dig, plant, sow, and weed at leisure hours, so as to make it both an exercise and amusement, while it produced many of the necessities of life.—William Buchan: Domestic Medicine, or a Treatise on the Prevention and Cure of Diseases by Regimen and Simple Medicine, etc. Philadelphia, Richard Folwell, 1799, p. 54

Intrauterine Contraceptive Devices

North Carolina Experience

ANN H. HUIZENGA, M.D.

RALEIGH

"There is not any argument about the necessity for attempting to prevent further births by the woman who has eight or ten children and who is diseased and whose life would be in jeopardy by further child-bearing. The problem is to do something about it before that stage is reached. We are interested only in the medical indications upon which practically every physician would be in agreement, that is in trying to legitimately prevent further births among women who are bad risks, both for themselves and their babies."¹

With this statement contained in an informal letter written to local health directors of North Carolina in 1937, Dr. George M. Cooper, then Assistant Health Director, launched the first state contraceptive program. He made it clear that this service was to be voluntary, that it was to be rendered in strict accord with medical opinion when undertaken, and that it was to be under the direction of the local health director.

This was only the beginning of a series of "firsts" in contraception in North Carolina. In 1938 the first paper ever given on contraception at an American Public Health Association meeting was delivered by Dr. Roy Norton,² then Assistant Director of the Division of Preventive Medicine, at the Association's annual meeting in Kansas City, Missouri. One year later the North Carolina program was given national recognition in an article entitled "Birth Control—The Case for the State," published in the widely circulated periodical, the *Atlantic Monthly*.³

In 1960 the Public Health and Welfare Departments of Mecklenburg County jointly began a unique venture of using the then newly released contraceptive pill. This venture has received so much publicity that many over-

look those North Carolina counties which for years have provided contraceptive services, continuously and diligently, but quietly and without publicity.⁴

In 1963 the privilege of participating in the National Cooperative Study for the statistical evaluation of the intrauterine contraceptive device gave North Carolina the opportunity to recommend this method for statewide use as soon as it became available in 1964.⁵

Recommendations to the Counties

There are not now, nor have there ever been, any laws necessary in North Carolina to permit or prohibit physicians from giving contraceptive advice. We are practicing in one of the few states in which physicians are given complete freedom in this respect. Since our local health departments are autonomous, the ultimate decision as to the policies to be adopted and practiced is that of each county. Therefore, the State Board of Health has drawn up no statement as to policies. Acting in the capacity of consultant only, it does propose certain recommendations to be used as guidelines to those counties in providing this service. Presently these are:

1. That these services be provided under medical direction, that they have the approval of the local medical society, and that they be given by a local physician.

2. That the services, since they are a part of total maternal care, be given in conjunction with the maternal health clinics.

3. That these services be primarily for the medically indigent but that they be available to anyone who requests them but who cannot or will not for some reason obtain them from his own physician.

4. That no person be denied because of inability to pay.

5. That each patient be given a physical examination, at least a pelvic examination, and a cervical cytology smear. This is an op-

Read before the Section on Obstetrics and Gynecology, Medical Society Meeting of the State of North Carolina, Asheville, May 3, 1966.

From the North Carolina State Board of Health, Raleigh.

portunity to extend good preventive medicine to a group which ordinarily will neglect a regular periodic examination.

6. That information regarding a variety of methods of contraception for both husband and wife be given so that some method will be available which is consistent with their religious beliefs, cultural and ethnic mores, personal preferences, and financial status.

7. That each couple be allowed to choose the method most acceptable to them, of their own free will, and without external pressure—the final decision to be made with the advice of the attending physician.

8. That no one "best" method can be advised. For husbands it may be the effective but unrealistic selective abstinence, the always available but challenging or frustrating "withdrawal," the readily available but often objectionable condom, or the surgical but more permanent vasectomy. For wives it may be the complicated and unpredictable rhythm, the simple but messy vaginal jellies and creams, the more esthetic aerosol foams, the sophisticated but time-consuming diaphragm, the popular but more expensive pill, the intriguing but sometimes elusive plastic intrauterine device (IUD), or again the surgical but theoretically more permanent sterilization. For the unmarried, nothing has surpassed the oral contraceptive. "No."

9. That those counties undertaking the responsibility of giving this service to the unmarried minor consult their county attorney for legal advice. In the use of the IUD by any unmarried woman under 21 years of age, permits for this service should be signed by the parents or legal guardian and filed.

10. That each county define, in writing, a set of policies to meet its particular need.

Growth of the Services

During the first year of the state contraceptive program, assistance in setting up services was provided by a specially trained nurse consultant who was supported by gifts from a private source. Later these services were continued by a general nursing consultant whose special interest was planned parenthood, and by a medical consultant—both from the State Board of Health. When Dr. Norton made his report to the American Pub-

lic Health Association 18 months after the services were first offered,² 56 clinics had begun operation in 50 counties. In 1957, when the Maternal and Child Health Services in North Carolina were reviewed by Dr. James Donnelly, 74 counties were participating in the contraceptive program. A number of changes recommended at that time have been largely responsible for our present progressive program.

The techniques used were varied, and interested counties grasped at any new method showing promise. Earlier methods consisted of sponge and foam, vaginal suppositories, tablets, capsules, jellies, and cream. A few urban centers offered the diaphragm with jelly. All methods, however, required constant motivation by the patient.

Acceptance of IUD

Though "the pill," the first breakthrough in modern contraception, was released in 1960, it is interesting to note that local units were slow in accepting it. By the end of 1963 annual reports showed only 21 of the 74 counties offering this method. By contrast, within two years after the release of the IUD in 1964, at least 65 counties are offering this method. Several reasons may be responsible for this:

1. In the war on poverty, public opinion on contraception has changed from one of permissiveness and suppressed interest to active participation and demand. In the face of increasing numbers on welfare rolls and rising rates of illegitimacy, this method has been hailed prematurely as "the answer" by various social agencies.

2. At the time of release of the IUD, some 10 counties scattered over the Eastern and Piedmont area had already been using the method on an experimental basis for six months to a year. The satisfactory experience of these counties was already well known throughout the state.

3. Some counties offering the pill had already experienced a discouraging number of dropouts. Also, the cumulative cost of the pills, year after year, was causing concern.

In all fairness it must be mentioned that public demand and interest revitalized the entire state program. The number of counties

offering the pill had increased to 67 in 1965, and the total number of counties participating in the program to more than 90. Only four counties have no contraceptive services offered or planned. It is safe to assume that even in these four counties, information is available to at least some people through the local physicians.

The tremendous surge in interest, growth, and acceptance of contraceptive services is witnessed by annual reports showing that in public health clinics only, the number of new patients seeking service increased from some 1000 in 1960 to 2226 in 1963, 5424 in 1964, and 8414 in 1965. Health departments are now doing about as much as they can, though the demand continues to grow.

Mode of Action and Techniques

The concept of the IUD is not new. The recent surge of interest in and acceptance of the device has been due to a combination of factors—the availability of inert cheap plastic, the effectiveness of the method, and the fact that it does not require constant motivation on the part of the patient.

The exact mode of action is not known, though the most widely held current opinion is that tubal transport is hastened, causing the ovum to be discharged before fertilization takes place.

Regardless of size, shape, or material, the devices can be divided into two groups—those totally contained in the uterus, and those having an appendage protruding through the cervical canal. The optimum time for insertion is in the last days of the menstrual period.

The device is not offered to nulligravida women. Other contraindications are the presence of fibroids, a history of unexplained irregular bleeding, a recent history of pelvic disease, lesions suggestive of malignancy, and, of course, pregnancy.

We have used the Margulies spiral, the Birnberg bow, and the Lippes loop. Though the Birnberg bow is designed as a tailless device, we thought that an appendage such as the nylon thread on the loop and the stiff tail on the spiral was advantageous, and we have therefore added a nylon tail to our bows.

Results

Our experience with 1500 patients who have had IUD's inserted one or more times and who have been followed from 5 to 34 months gives, we believe, some indication of the effectiveness, acceptability, and complications which might be expected in our public health clinics.

As of March 30, 1966, these 1500 women have had a total of 1822 insertions and have accumulated 18,986 woman months of use. Roughly two thirds of this number (1046) are currently wearing one of the devices. Sixty-one have been transferred elsewhere with the device in place, 375 have dropped out, and 16 are at present lost to followup.

Effectiveness: Eighteen pregnancies occurring with the device known to be in place have been reported, giving a combined rate of 1.02 per 100 woman years of use. Another group of 11 women are considered in retrospect to have been pregnant on insertion. Since some of these pregnancies might actually have followed an unnoticed expulsion of a previous device, they might rightfully be included in calculating the pregnancy rate. Three of the pregnancies were ectopic—discovered at surgery.

Expulsions: Two hundred forty-eight of the originally inserted devices were expelled—a combined rate of 16.5%. Specific rates by devices were 25.1% for the spiral, 13% for the loop, and 2.8% for the bow.

Cause of removals

Two hundred seventy-six patients, roughly 18%, have had at least one device removed. Reasons related to the device were responsible in 202 cases; the most frequent were bleeding, cramps, or both. In three instances bleeding or pain was so severe that the device had to be removed before the patient left the clinic. Thirty-one devices were removed because of pelvic inflammatory disease, or "infection."

Of the nonrelated reasons for removal, cytologic abnormalities, objection on the part of the husband, and desire for another pregnancy were the most common.

We have not experienced any serious complications with the use of these devices. No perforations of the uterus into the peritoneal

Table 1

Related Reasons for Discontinuing Use of Intrauterine Device

	No. Cases
Bleeding and/or cramps	116
Pelvic inflammatory disease "infection"	31
Exchange	13
Request of patient	10
Removal by patient	7
Desire to try pills	6
Emotional immaturity of patient	5
Physician error or prejudice	5
Promiscuity	3
Pregnancy	3
Unfavorable publicity	3
Total	202

cavity have been reported. We have had 6 perforations of the cervix by the stiff Marguilies spiral tail. In some instances, the device was drawn into the uterine cavity, where it was located either by probing or x-ray.

The incidence of true pelvic inflammatory disease has been hard to determine, since the word "infection" is used loosely; however, 16 cases required hospitalization. Of these, 4 were proved at surgery to be inflammatory conditions, 3 were found to be cases of ectopic pregnancy, and 2 were primarily other non-inflammatory conditions. The remaining 7 were treated medically.

Any method of contraception having a 20 to 30 per cent attrition rate is obviously not the answer to unwanted pregnancies. Experimentation is continuing in an effort to determine the optimum size, shape, or design which will maintain a high level of efficacy and yet decrease the incidence of minor complications. Even with its failures, however, the IUD offers hope to many of our patients in whom previous methods have failed, and until a better method is found, we shall continue to offer it to those who are interested.

Summary and Conclusion

Obstetrically speaking, the North Carolina contraceptive program was conceived naturally as the result of a personal need to improve maternal and infant health, not created artificially by the war on poverty. Its ante-

Table 2

Unrelated Reasons for Discontinuing Use of Intrauterine Device

	No. Cases
Desire for pregnancy	14
Husband's objection	16
No longer necessary	6
Accidental	1
Abnormal cytology	26
Elective surgery	9
Psychiatric conditions	1
Patient left county	1
Total	74

partum course was not complicated by restrictive legislation or adverse public criticism. Its birth occurred spontaneously when the time was ripe; it was not induced by outside agents such as the federal government, world demographers, and social reformers. Its postnatal course has been marked by periodic check-ups, with the incorporation of regular "boosters" as they have been released by medical science. Its foundation is firmly established; it will continue to grow in quality and stature.

In short, the North Carolina contraceptive program is a medical service whose aim is *health*, in a broad sense—health of the moth- and infant, health of the family, and health of the community. As other agencies become involved, it is rapidly ceasing to be a privilege enjoyed by us physicians; it is becoming rather an obligation and responsibility. HEALTH is our responsibility. Let us keep it in our hands.

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Report on Trauma

THE EARLY MANAGEMENT OF CLOSED FRACTURES*

The end result of any fracture may be jeopardized by careless initial treatment.

In the early management of closed fractures, the physician must keep in mind certain basic principles. Treatment of the closed fracture comes *fourth* in the order of emergency measures for a severely injured patient. Only after an adequate airway has been established, active hemorrhage has been controlled, and shock has been reversed, should closed fractures be treated.

The old axiom, "Splint them where they lie," which became popular during World War I when traction splinting reduced the mortality of front-line open fractures of the femur from 80 to 16 per cent, remains true today. The gentle application of a splint, even before a definite diagnosis has been made, is good practice.

What type of splint should one use? *Any method which prevents further damage without embarrassing the circulation is proper fracture treatment.* The Thomas ring splint has proved satisfactory. Excessive traction is dangerous, especially over a long period of time, but there must be enough traction to prevent further nerve, vessel, or other soft tissue injury.

Ideal splinting includes a secure method

of fastening the arm or leg to the splint, but without injuring the extremity. Adequate padding or leaving a shoe on works quite well. The traction should be applied above the wrist or ankle, and there should be some method of increasing and decreasing the traction. This may be done with a windlass device such as twisting a small stick in the attachment from end of extremity to end of splint. The extremity should be supported as well as in traction, and lateral motion should be prevented. The entire splint should be supported.

Careful re-evaluation of the distal sensation, motor function, and circulation after splinting is essential. The patient is now ready for transportation to x-ray or to an area of definitive treatment.

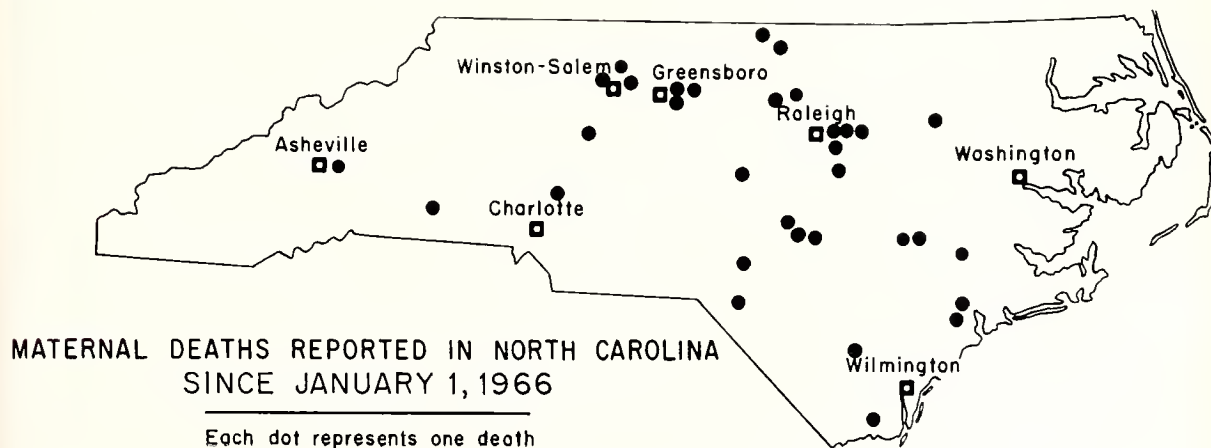
Lastly, it should be remembered that a considerable amount of blood, estimated up to 1500 cc., can be lost in the soft tissues about a closed fracture of a femur. Multiple close fractures can quite easily result in adequate blood loss to produce hypovolemic shock. Appropriate management is, of course, early and adequate replacement with properly matched whole blood.

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A new educational film, "The Wyeth Story", covers a full century in the growth of medicine as it depicts the growth and modern dimensions of Wyeth Laboratories, both in the United States and abroad.

Available on loan for group showings, "The Wyeth Story" is 16 mm., sound, 40 minutes in full color. For showings, write to Wyeth Film Library, Box 8299, Philadelphia, Pa. or telephone Murray 8-4400 in Radnor, or any local Wyeth representative.

This is the eighth in a series of articles submitted by the North Carolina Chapter of the American College of Surgeons Committee on Trauma.



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SEPTEMBER, 1966

MIDSUMMER EXECUTIVE COUNCIL MEETING

Pressing issues, particularly the implementation of Resolutions Numbers One and Two enacted by the House of Delegates last May, concerned with the posture of the State Society regarding payment for services under Medicare and other government programs, occasioned the called meeting of the Executive Council in Raleigh, July 31.

The Council authorized the Committee on Negotiations to proceed in its deliberations with governmental agencies on the basis of

"Usual and Customary" fees. Complex problems involved in bringing existing service programs in line with these resolutions must be recognized. Much deliberation and time will be required to accomplish their objectives.

The implications of Title XIX, Public Law 89-97, actually an extension of Kerr-Mills and expected to expand and replace it ultimately, were given attention. When and if fully implemented, this legislation will provide possible benefits for upward of 35,000,000 citizens. The law stipulates that each state must participate in Title XIX by 1970 in order to continue to receive federal support for other governmental programs. The Council endorsed the designation of the State Board of Health as the Administrative Agency under Title XIX.

The Council received a report from the State Board of Health, designated as the Administrative Agency for Medicare, indicating that 133 of 176 North Carolina hospitals have been approved for participation in Medicare. Twenty-one hospitals were chosen not to participate. Of the remaining 22, 10 have not qualified and the remaining 12 are pending. It is of interest to note that in no instance did a hospital fail to qualify because of a lack of a utilization and review plan.

The Council was given a progress report on a proposed implementation of Public Law 89-239 known as the "DeBakey Bill." Through the close cooperation of the Medical Society, the medical schools, and the State Board of Health, a planning grant has been secured and an Association of the North Carolina Regional Medical Program has been organized. It is anticipated that the planning phase will require approximately two years and will involve the employment of a planning director, already designated, and a medical director, to be appointed in the near future.

Among other matters considered by the Council was the election of Dr. Hugh F. McManus, Jr., Raleigh, to fill out the unexpired term of the late Dr. Harry L. Johnson, Elkin, on the Medical Care Commission. The Council authorized appropriate recognition for the dedicated service of Dr. Johnson to the Society and to the state.

J.S.R.

DR. SHAFFNER'S DIARY

Shaffners have been publishing in the official journal of the Medical Society for almost 100 years now, and there being an adequate supply of boys in the present generation, they may well extend the tradition another 100 years. In the *Transactions* of the Society for 1868, the Dr. Shaffner whose diary is excerpted in this issue of the JOURNAL published an account of some surgical cases. In the *Transactions* for 1872, the "Henry Bahnson" of Dr. Shaffner's diary, now Dr. Henry Bahnson, published an account of some "guinecological" cases. one of them a lady referred to him by Dr. Shaffner. He took advantage of having the floor with his gynecologic cases to enter a plea on behalf of women in medicine, and to recommend the admission of a certain lady to membership in the Society.

A few items concerning Drs. Shaffner and Bahnson may interest those who have read Dr. Louis Shaffner's paper. Dr. J. F. Shaffner returned to Salem, N. C. after the war, and in addition to a large practice of medicine gave freely of his time to organized medicine. He was, among other offices, chairman of many committees, delegate to the American Medical Association from the Medical Society of the State of North Carolina in 1872, and President of the Society in 1880.

Dr. Henry Bahnson, who was only 18 years old at the time he appears in Dr. Shaffner's diary on the field at Gettysburg, was exchanged as a prisoner and fought on until Appomattox, returning home after he had been given up for dead, and indeed was not far from that state when he arrived among his family. He got the M.D. degree from the University of Pennsylvania and returned to Salem to practice. Like Dr. Shaffner, he was active in medical affairs, being President of the State Society, President of the State Board of Health and Secretary of the State Board of Medical Examiners. His descendants, like Dr. Shaffner's, remain active in medicine today.

SOME MEDICAL EFFECTS OF
TIGHT PANTS

Any male who has lately bought a pair of pants, even if he is inclined toward the conservative, must have noted that the carrying capacity of current styles is smaller (in many cases the volume to be contained is larger, too). Those addicted to taking their pants off with their shoes on have an almost impossible task. Should present trends continue it will soon be unnecessary to dress the attendants at historical sites in replicas of the clothes of 200 years ago; our own styles will do.

Aside from the appeal to vanity, the shame cast upon the hanging belly by such styles, the newer pants cannot help but put into relief difficulties in the inguinal and perineal regions. There will be no concealing of hernias among the folds of expanding pleats. Hydroceles will make anything but a costume party where he can go in a toga an impossibility for the sufferer. In short, they will aid in bringing the wearer to the physician.

History, however, tells us that this was not always precisely the case. That supreme example of 18th century scholarship, Edward Gibbon, suffered from a hydrocele. The styles of that era made his problem apparent to discerning friends, but he was never given their advice on the subject (as a bachelor he was deprived of therapeutic nagging). The size of the swelling was such that for years he did not mind going out in society, though one suspects from the length of *The Decline and Fall of the Roman Empire* that his difficulty kept him home most of the time. Near the end of his life the swelling suddenly increased greatly, and he was unable to dress acceptably to go out in the company of his friends. Finally, after a lapse of many years after a hesitant diagnosis of hernia versus hydrocele had kept him away from physicians, he again sought medical advice, had a hydrocele diagnosed and drained, and died of infection. Today, the outcome would have been different, but at age 57 he would still have to pay for his own operation.

The President's Page

DOCTORS ARE NOT RAISING FEES; THEY ARE DECREASING DISCOUNTS

When a man stops listening to or reading the opinions of others he is intellectually rigid. Editorial pages of newspapers and magazines have always been of great interest to me. I would be less than honest if it were not also said that often the opinions set forth on those pages are at total variance with my thinking. On the other hand when an angle or thought is brought out by another man's thinking that I had not considered, it at least causes me to re-evaluate my own position.

From time to time a train of thought is encountered that somewhat parallels my own. Last week, while in Chicago attending a series of four separate meetings, I happened upon an editorial in the *Chicago Tribune* of Saturday, August 27, 1966.

This editorial is the reaction, the thinking, and the observations of a layman. We quote this editorial in full, not because we feel that Mr. W. D. Maxwell or a member of his editorial staff is an advanced thinker because he seems to agree with our thoughts, but because the treatment of the subject matter is timely, thoughtful, and objective.

Before quoting the editorial itself it is wise to allow the Tribune Credo, a part of their masthead, to speak.

The Newspaper is an institution developed by modern civilization to present the news of the day, to foster commerce and industry, to inform and lead public opinion, and to furnish that check upon government which no constitution has ever been able to provide.

As one reads the last statement of this Credo, the awesome responsibility of the communications media becomes critically apparent. Allen Drury in a new (1966) political novel, *Capable of Honor*, brings out what might happen when a responsibility of reasonableness becomes a license of power.

Read for yourself this *Tribune* editorial, and I am sure you will see why it is being reproduced. It does not consider that Medicine, in its entirety, is like Sir Lancelot in pursuit of the Holy Grail—totally pure and without reproach, but it does point out that we should not be prejudged and preconvicted, before the fact, if and when the Medicare

program demonstrates the problems that are built into it.

The *Tribune's* spelling of "burocrat" intrigues me greatly. Webster makes real interesting reading to one seeking the meaning of the prefix *bur* or *burr* as used in this context.

THE BUROCRAT AND THE DOCTOR

A spokesman for medicare, commenting on a report that doctors have raised their fees for elderly patients by "as much as 300 per cent" since the program began, jumped to a hasty and predictable conclusion. "This is a situation," he told the New York Times, "in which the professional takes advantage of the plan."

President Johnson has lent credence to this charge by ordering a study of rising medical costs.

Ever since George Bernard Shaw, the Fabian socialist, wrote "The Doctor's Dilemma," advocates of government controlled medicine have tended to blame the doctors for everything that has gone wrong in their profession.

What the Times report boiled down to was simply that many doctors who have been treating the elderly and indigent at cut-rate fees, out of consideration for these patients, are raising the fees to conform to their standard fees. "I'm not raising fees," one doctor protested, "but eliminating a discount."

This doesn't strike us as unreasonable. There is no reason why a doctor who has been helping elderly patients by charging less than the going rate should now be expected to grant the same subsidy to the government—especially when he is paying social security taxes himself for benefits which, in all likelihood, he will never receive. Doctors rarely retire at 65, and with today's shortage there is more need than ever for them to stay on the job.

If the government, for its part, wants the elderly to receive the quality of care that they have been promised under the voluntary, supplemental program to which nearly all of them have subscribed, it hardly makes sense for it to refuse to pay what other patients pay.

This isn't to say that all doctors are perfect or that there won't be any abuses on their part. But when a government spokesman suggests that the medical profession is profiteering simply because doctors object to subsidizing the government more than they already are, the doctors can't be blamed for looking at the whole program with a jaundiced eye.

This is the way schisms have developed between doctors and bureaucrats wherever a government has stepped into the practice of medicine. If it is an indication of the way things are to be here, too, the prognosis for medicare is a gloomy one.

FRANK W. JONES, M.D.

Correspondence

To the Editor:

The following information may be of interest to your readers.

There is a narcotics addict traveling about North Carolina and Virginia in search of drugs, who can very easily be identified.

He is 59 years of age, has white hair, blue eyes and is rather plump. He is very genial natured. In addition, he has a long transverse suprapubic scar of recent origin. This patient may present a spurious Blue Cross card.

I am purposely omitting his name so as not to lay myself open to a libel action.

Norman M. Hornstein, M.D.
Southport, N. C.

Bulletin Board

Coming Meetings

Fifth District Medical Society Meeting—The Country Club of North Carolina, Pinehurst, October 5.

University of North Carolina School of Medicine, Conference on "Grief and Depression—Their Crisis and Management"—Chapel Hill, October 6-8.

The Herman Cone Lecture, sponsored by the Moses H. Cone Memorial Hospital—Greensboro Public Library, Greensboro, October 20. Dr. Curtis P. Artz, of the Medical College of South Carolina will be the speaker.

North Carolina Academy of General Practice, 1966 Scientific Assembly—Hotel Jack Tar, Durham, October 27-28.

North Carolina Society for Crippled Children and Adults, Annual Convention—Mid Pines Hotel, October 28-29.

Society of Nuclear Medicine, Southeastern Chapter—Jack Tar Hotel, Durham, November 3-5.

Southern Thoracic Surgery Association, 13th Annual Meeting—Grove Park Inn, Asheville, November 3-5.

North Carolina Pediatric Society—Mid Pines Club and Golfotel, Southern Pines, November 4-5.

Greensboro Academy of Medicine, 20th Annual Symposium—Greensboro, March 30, 1967.

American College of Surgeons, 52nd Annual Clinical Congress—San Francisco, October 10-14.

American Academy of Pediatrics—35th Annual Meeting, Chicago, October 22-27.

NEW MEMBERS OF THE STATE SOCIETY

Drs. John Tilmon Gentry, 2018 N. Lake Shore Dr., Chapel Hill; George Thomas Arnold Morris, 711 Hermitage Rd., Burlington; Mary Lide Morris, 1704 Woodland Ave., Burlington; William Glenn Myrick, Kernodle Clinic, Burlington; John Walter Paisley, Jr., P. O.

Box 985, N. Wilkesboro; Walter Harley Davidson, Path, Scotland Mem. Hosp., Laurinburg. Edward Everard Low, P. Broughton Hospital, Morganton; Charles Walker Harris, I. 1351 Durwood Dr., Charlotte; Joe Thomas Fox, Jr., P. 1928 Randolph Rd., Charlotte; Joseph Walter Stiefel, N. 1126 N. Elm St., Greensboro; Montford Haslam, GP. Barket St., Hertford; Philip Thomas Howerton, R. Powe St., Morganton; Lonis Leon Schurter, 505 Northwood Circle, Garner.

NEWS NOTES FROM THE BOWMAN GRAY SCHOOL OF MEDICINE OF WAKE FOREST COLLEGE

Avalon Foundation of New York City has appropriated \$200,000 to the Bowman Gray School of Medicine for use in the construction of new medical school facilities.

The grant, which will support the \$27-million expansion program of the medical school and North Carolina Baptist Hospital, was announced jointly by Charles S. Hamilton Jr., president of Avalon Foundation, and Dr. Manson Meads, medical school dean.

Avalon Foundation, created in 1940 by Mrs. Ailsa Mellon Bruce, has had an active interest in health and medicine from the beginning of its operation. In recent years the foundation has provided aid for education in the health sciences, including physical facilities.

Construction of an 86,000-square-foot addition to the Bowman Gray School of Medicine is scheduled to begin in February, 1967. Contracts for the construction of other elements of the expansion program including hospital facilities, will be awarded at a later date.

These projects, which will enlarge the medical center by 80% and will increase the number of hospital teaching beds from 483 to 717, are designed to permit a 37% increase in medical school enrollment and a significant expansion of the graduate and postdoctoral programs.

* * *

Dr. John T. Hayes, a member of the University of Michigan Medical School faculty for the past 10 years, joined the faculty of the Bowman Gray School of Medicine July 1 as professor and director of the Section on Orthopedics.

Other newly appointed faculty members are Dr. Robert H. Coombs, assistant professor of sociology; Dr. Alvin H. Gold, assistant professor of biochemistry; Dr. Robert M. Kerr, assistant professor of medicine; Dr. Richard Janeway, instructor in neurology; Dr. Paul Lambrecht, instructor in medicine; Dr. C. Douglas Maynard, instructor in radiology; and Dr. Timothy C. Pennell, instructor in surgery.

Dr. Hayes, who holds the B.S. and M.D. degrees from the University of Michigan, was appointed to the faculty of the University of Michigan Medical School in 1956, following the completion of internship and residency training at University Hospital in Ann Arbor, Mich. He was promoted to associate professor of orthopedic surgery in 1962.

Dr. Coombs, a faculty member at Iowa State University for the past three years, is a sociologist in the

Section on Marriage and Family, Department of Obstetrics and Gynecology. He holds the B.S. and M.S. degrees from the University of Utah and the Ph.D. degree from Washington State University. A recipient of the Bobbs-Merrill Award in Sociology, he is currently writing a book on "Social Changes and the Family."

Dr. Gold, who holds the B.A. and M.A. degrees from the University of Texas and the Ph.D. degree from St. Louis University School of Medicine, has studied for the past two years as a research associate at the State University of New York at Buffalo.

Dr. Kerr, a gastroenterologist, recently completed a two-year fellowship with the Cornell Medical Division of Bellevue Hospital, New York City. A graduate of Bucknell University, he attended the University of Pennsylvania Graduate School of Chemical Engineering and received the M.D. degree from Cornell University Medical College.

Dr. Janeway, who completed residency training in neurology June 30 at N. C. Baptist Hospital, will serve as program director of the Cerebral Vascular Research Unit of the Department of Neurology. A magna cum laude graduate of Colgate University, he holds the M.D. degree from the University of Pennsylvania School of Medicine, where he also took internship training. He is a member of Phi Beta Kappa and Alpha Omega Alpha.

Dr. Lambrecht, a native of Courtrai, Belgium, is engaged in gastroenterology research. He holds the M.D. degree from the University of Louvain, Belgium, where he has studied for the past year as a resident in cardiology. A former fellow in medicine at Bowman Gray, he took postdoctoral training at hospitals in Philadelphia, Pa., and Antwerp, Belgium.

Dr. Maynard, who recently was named a James Picker Foundation Scholar in Radiological Research, is now in charge of the Nuclear Medicine Unit of the Department of Radiology. A graduate of Wake Forest College and the Bowman Gray School of Medicine, he completed residency training June 30 at N. C. Baptist Hospital.

Dr. Pennell, who has been awarded a fellowship by the American Thoracic Society, is a graduate of Wake Forest College and the Bowman Gray School of Medicine. He recently completed residency training in general and thoracic surgery at N. C. Baptist Hospital.

* * *

Dr. Richard L. Burt, professor of obstetrics and gynecology, was recently appointed to the editorial board of "Obstetrics and Gynecology," the official journal of the American College of Obstetricians and Gynecologists.

* * *

Dr. Thomas B. Clarkson, Jr., professor and director of the Department of Laboratory Animal Medicine, has been appointed to a four-year term on the Animal Resources Advisory Committee of the National Institutes of Health as a special consultant to the Public Health Service. His appointment became effective July 1.

* * *

Dr. Hugh J. Burford, assistant professor of pharmacology, presented a paper on "Extrarenal Avian Salt

Excretion in Relation to Cardiovascular Function" at the annual meeting of the American Society of Pharmacology and Experimental Therapeutics in Mexico City, Mexico.

* * *

Forty-nine interns and resident physicians were recently appointed to the house staff of N. C. Baptist Hospital and the Bowman Gray School of Medicine. There are presently 114 doctors who are continuing their postdoctoral training as members of the medical center house staff.

NEWS NOTES FROM THE UNIVERSITY OF NORTH CAROLINA SCHOOL OF MEDICINE

Two sections of interstate highways in North Carolina have been selected for a federally sponsored study aimed at reducing highway accidents and improving emergency medical services for persons injured on the highway.

UNC's Department of Hospital Administration has been awarded \$125,000 for the first six months planning phase of the study. The total study is expected to cost \$400,000 and require about 18 months.

Colonel Harvey E. Archer of the UNC Department of Hospital Administration is the director of the study.

He said that a 40-mile section of I-40 from Black Mountain east to Hildebran and a 50-mile section of I-85 Greensboro and Durham will be used for the study.

The N. C. Highway Commission and the N. C. Department of Motor Vehicles will participate in the study as well as a number of hospitals yet to be selected.

* * *

Dr. Hasan I. Zeya, a research associate in bacteriology at the UNC School of Medicine, has been awarded a special scholarship grant by the Leukemia Society.

The two-year grant will provide \$19,000 for Dr. Zeya's research into the chemistry of white blood cells. He is seeking a better understanding of the tendency of leukemia victims to die of infection.

* * *

Three members of the UNC medical faculty were promoted by University trustees at their July meeting.

Dr. George K. Summer, pediatric biochemist was promoted to associate professor.

Promoted to assistant professors were Dr. James A. Bryan, medicine, and Dr. Harvey E. Mayberry, anatomy.

* * *

Dr. Ivor S. Smith, a native of Northern Rhodesia and now a U. S. citizen, joined the UNC medical faculty as assistant professor September 1.

* * *

Dr. Peter Hutchin, a native of Czechoslovakia, has joined the UNC School of Medicine as an instructor in surgery.

For the last two years he has been a U. S. Public Health Service Fellow working in the field of transplantation at Duke University Medical Center. His primary research interest is in lung transplantation.

Miss L. Irene Hollis, director of occupational therapy at the University of North Carolina's Hand Rehabilitation Center, spoke in London, England, in late July at the annual meeting of the World Federation of Occupational Therapists.

She reported on "Splint Substitutes," presenting some original ideas on the use of inexpensive and readily available materials as replacements for elaborate splints in rehabilitating patients with injured hands and arms.

* * *

The biology of the outer layers of the human skin—the epidermis—will be studied at the UNC School of Medicine under a new three-year federal grant. A first-year grant of \$54,533 was approved by the National Institute of Arthritis and Metabolic Diseases.

The project director is Dr. Clayton E. Wheeler, Jr., UNC dermatologist.

* * *

A hunch that lectures would mean more if medical students could work with patients earlier in their training has led to a special study at the UNC School of Medicine in Chapel Hill.

Traditionally, medical students first work with patients in their third year of medical school. Now, a federal grant of \$19,400 has been approved to conduct a three-year pilot and evaluation program under which pre-freshmen medical students volunteer to spend the summer before entering medical school working in a hospital setting.

The program is under the direction of Dr. John A. Ewing, chairman of the UNC Department of Psychiatry.

Results of the study could help medical schools decide whether to seriously consider introducing students to patients earlier than the traditional third year.

* * *

Dr. Hugh M. Shingleton, obstetrician-gynecologist at the UNC School of Medicine and N. C. Memorial Hospital, departed in July for New York City and a year of basic research related to female cancer.

He was awarded a Special Postdoctoral Fellowship by the National Cancer Institute.

Dr. Shingleton will work in the departments of obstetrics-gynecology and pathology at Sloane Hospital for Women, a unit of Columbia-Presbyterian Hospital in New York City.

* * *

Funds for a new infirmary building to house the Student Health Service at the University of North Carolina in Chapel Hill will be requested from the 1967 General Assembly.

The proposed building would replace the present infirmary financed jointly by UNC and the Navy and built in the early days of World War II.

* * *

Four graduates of an on-the-job training program for operating room technicians received their certificates at special ceremonies at N. C. Memorial Hospital at the end of June.

This was the fifth class to complete the 16-week program. The training is the first of its kind established in the state under a contract with the U. S. Labor Department.

A special technique for taking color movies of tiny, finger-like projections on the inside lining of the small intestine of living animals has been developed at the UNC School of Medicine.

It marks one of the first times in the U. S. that the pumping and swaying motions of intestinal villi have been photographed in color.

* * *

The first in a series of training programs and other services for community action programs were held for community action agency directors at UNC in mid-July.

Dr. Wilbert Edgerton, associate professor of psychology and psychiatry, and Dr. William Hollister, head of community psychiatry, directed the workshop. Emphasis was placed upon understanding one's own behavior in a small group situation, understanding the behavior of others, and development of skills in group leadership.

* * *

The National Cancer Institute awarded \$74,852 to the UNC School of Medicine to establish a new clinical cancer training program. The funds will finance the first year of a proposed three-year program.

Dr. James F. Newsome of the UNC Department of Surgery will be the program director.

The federal grant will provide an expanded teaching program in cancer treatment for undergraduate students, establish special traineeships for graduate students and expand postgraduate education for practicing physicians.

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ASHEVILLE, North Carolina

Three physicians in the Student Health Service at UNC have been promoted in Chapel Hill.

Dr. James A. Taylor, a native of Oxford who came to UNC in 1949 as an instructor in pharmacology, has been named university physician.

Promoted from assistant associate university physicians are Dr. Joseph L. DeWalt and Dr. Nicholas A. Love.

NEWS NOTES FROM THE DUKE UNIVERSITY MEDICAL CENTER

A program to help meet the need for well-trained physicians devoted to family and community health is being launched by Duke University Medical Center.

A key step in the program is changing the department of preventive medicine to the department of community health sciences.

"Our aim," said Dean W. G. Anlyan, "is to create a new physician—one who will bridge the gap between the exciting advances being made at the research level of medical sciences and their application at the family and community level."

Dr. E. Harvey Estes has been appointed chairman of the new department.

Dr. Estes, who also is secretary-treasurer of the Durham-Orange County Medical Society, played a major role in setting up the North Carolina Regional Medical Program, now in the planning stages as part of the President's war on heart disease, cancer, stroke and related diseases.

* * *

Dr. Allan H. Pribble, who recently completed his internship in medicine at Duke University Medical Center, is one of seven U. S. Public Health Service medical officers being sent to South Vietnam.

Dr. Pribble, received his M.D. degree from Washington University, St. Louis, Mo., a year ago and then began his internship at Duke.

He has been assigned to duty with the Agency for International Development of the U. S. State Department and will work in civilian hospitals in Da Nang and Nha Trang.

* * *

A continuation grant of \$48,895 has been awarded Duke University Medical Center by the National Institute of Arthritis and Metabolic Diseases for a postgraduate training program in academic urology.

The grant is intended to provide basic training and

fundamental experience for prospective and promising academic urologic surgeons. The five-year program was started last year under the direction of Dr. James F. Glenn, chief of the division of urologic surgery.

"The emphasis in the program," said Dr. Glenn, "is on helping meet the need for teachers in urologic surgery by developing appropriate candidates for positions in medical centers throughout the country."

The trainees receive instruction and experience in areas of investigative urology, clinical urologic surgery, basic research, and teaching.

* * *

A clinical study of human macular disease, a condition that affects the central sharp vision of the eye, will be conducted at Duke University Medical Center under a \$35,048 U. S. Public Health Service grant. The grant will enable researcher's in Duke's new eye clinic to learn more about the puzzling disease which is generally associated with aging but can also occur in the young. It covers the first year of a three-year project.

"We will take a close look at the anatomy of the eye's blood vessels which influence the central vision," said Dr. Joseph A. C. Wadsworth, chairman of the Department of Ophthalmology, who has been named principal investigator.

Because human macular disease has been found to be hereditary, a genetic cause will also be sought. Medical records at Duke show that in the 12 years between 1952 and 1964, macular disease was found in 1,123 patients.

Research here will involve:

1—A study of the microscopic changes that occur within the diseased eye.

2—Use of the hyperbaric chamber in an attempt to determine the utilization of oxygen within the eye.

3—Use of a technique called fluorescein photography in which a dye is injected into the patient's bloodstream to enable the doctors to study the normal and abnormal blood supply to the retina.

Associated with Dr. Wadsworth in this research will be Dr. W. Banks Anderson, Jr., Dr. James Gills, and Dr. Arthur C. Chandler, all assistant professors.

* * *

Working on a new, U. S. Public Health Service grant of \$125,832 for three years, Dr. J. Graham Smith, a professor in the Department of Dermatology, Duke University Medical Center, will focus his microscope on cell structures which may be related to blister formation.



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His aim will be: (1) to test the hypothesis that enzymes that attack proteins and carbohydrates are released or activated to produce blisters; and (2) to find a better means of treating them.

At the moment, corticosteroids, a potentially toxic group of chemical agents, are being used successfully in the treatment of blistering diseases. Sometimes, though, relief of the symptoms is accompanied by dangerous side-effects when the corticosteroids are used in large doses or over long periods.

"We're looking for safer drugs," said Dr. Smith. "By knowing more about the causes of blistering we may in turn be able to come up with agents that will be just as effective as corticosteroids but less risky."

* * *

Dr. James F. Glenn a professor and chief of the Division of Urologic Surgery of Duke University Medical Center, has been appointed to the National Academy of Sciences Research Council committee on the genitourinary system.

Chairman of the academy committee is Dr. William H. Boyce of Bowman Gray School of Medicine in Winston-Salem.

* * *

Duke University Medical Center has been awarded a \$153,796 U. S. Public Health Service grant to demonstrate the effects of delegating the coordination of patient care services to unit administrators.

With the introduction of new medical knowledge and skills, the coordination of all patient services has become one of the major problems facing larger hospitals and medical centers.

The two-year grant was made to Charles H. Frenzel, administrative director of the medical center; Ralph E. Jennings, assistant director; and Dr. Jay Goldman, a consultant and professor of industrial engineering at North Carolina State University, Raleigh.

* * *

Dr. Charles Hayes, an assistant professor of medicine at Duke University Medical Center, has been appointed to the national Kidney Disease Project Review Committee.

The group consists of consultants who will advise the U. S. Department of Health, Education and Welfare on kidney disease projects.

* * *

The Fall Medical Center Weekend, an event which annually attracts many Duke University medical graduates, will be held this year on Nov. 17-19.

All alumni of the School of Medicine have been invited to return to the campus to learn what is going on in medicine at Duke today.

The Alumni Association will hold its annual luncheon and business meeting on Friday, Nov. 18. It will be followed by programs arranged by various departments in the medical center. A social hour, dinner, and dance for alumni will be held that night in the Jack Tar Hotel.

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Saturday morning's program includes tours of the medical center and a "brunch" for alumni, staff members, and guests. At 1:30 p.m., the Blue Devils football team will play the Tarheels at Kenan Stadium in Chapel Hill, and that evening, alumni groups will hold private social hours and dinners.

NORTH CAROLINA SOCIETY FOR CRIPPLED CHILDREN AND ADULTS

"Recreation for the Handicapped" is the theme chosen for the annual convention of the North Carolina Society for Crippled Children and Adults to be held in Southern Pines, October 28 and 29.

Lieutenant Governor Robert Scott will be keynote speaker of the convention.

Most of the meetings will be held at Mid Pines Golfotel. The President's Dinner, however, will be served ranch style in the Lodge at Camp Easter-in-the-Pines, the society's camp for handicapped children and adults.

AMERICAN ACADEMY OF GENERAL PRACTICE

Why do today's teenagers rebel? How can the family doctor reach them when their parents often can't? "The Angry Adolescent," a frank exploration of why "kids do what they do," is one of the highlights awaiting family doctors attending the first fall Scientific Assembly of the American Academy of General Practice, October 10-13 in Boston.

Sharing the Assembly spotlight with the adolescence panel will be other "in-depth" discussions on such timely topics as stroke, obstetrics and mental retardation, heart disease, and two half-days of bedside refresher courses at Massachusetts General and 13 other hospitals.

The Sheraton Boston will be the scene of the Delegates' Dinner Monday night and the President's Reception Wednesday night honoring outgoing president Dr. Amos N. Johnson of Garland, N. C. The reception will follow inauguration of the new president, Dr. Carroll L. Witten, Louisville, Ky.

U. S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

To identify the present state of knowledge concerning the initiation of labor, the National Institute of Child Health and Human Development sponsored an interdisciplinary conference in late 1963.

Proceedings of the three-day conference, held in Princeton, New Jersey, are now available in a 241-page, fully indexed volume entitled "Initiation of Labor."

The proceedings, edited by Dr. Jean M. Marshall, Assistant Professor of Pharmacology at Harvard Medical School, includes a summary and over a hundred tables and figures. Copies of the publication, PHS No. 1390, can be purchased from the Superintendent of Documents, U. S. Government Printing Office, Washington, D. C. 20402 for \$1.00.



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		Under Age 50	50-59	60-69
A—\$100 DEDUCTIBLE				
Member	<input type="checkbox"/>	\$ 40.50	<input type="checkbox"/> 58.50	<input type="checkbox"/> \$ 96.50
Member and Spouse	<input type="checkbox"/>	81.00	<input type="checkbox"/> 118.50	<input type="checkbox"/> 192.50
Member, Spouse and all children ..	<input type="checkbox"/>	112.00	<input type="checkbox"/> 148.50	<input type="checkbox"/> 217.50
B—\$300 DEDUCTIBLE				
Member	<input type="checkbox"/>	\$ 30.00	<input type="checkbox"/> \$ 44.50	<input type="checkbox"/> \$ 73.00
Member and Spouse	<input type="checkbox"/>	62.50	<input type="checkbox"/> 90.00	<input type="checkbox"/> 147.00
Member, Spouse and all children ..	<input type="checkbox"/>	86.00	<input type="checkbox"/> 113.50	<input type="checkbox"/> 164.00
C—\$500 DEDUCTIBLE				
Member	<input type="checkbox"/>	\$ 21.00	<input type="checkbox"/> \$ 30.00	<input type="checkbox"/> \$ 51.00
Member and Spouse	<input type="checkbox"/>	43.00	<input type="checkbox"/> 62.50	<input type="checkbox"/> 100.50
Member, Spouse and all children ..	<input type="checkbox"/>	60.00	<input type="checkbox"/> 78.00	<input type="checkbox"/> 112.00

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AMOUNT OF MONTHLY OVERHEAD EXPENSE		Under Age 55	55-59	60-64	65-69
\$1,000.00	<input type="checkbox"/>	\$200.00	<input type="checkbox"/> \$250.00	<input type="checkbox"/> \$300.00	<input type="checkbox"/> \$400.00
900.00	<input type="checkbox"/>	180.00	<input type="checkbox"/> 225.00	<input type="checkbox"/> 270.00	<input type="checkbox"/> 360.00
800.00	<input type="checkbox"/>	160.00	<input type="checkbox"/> 200.00	<input type="checkbox"/> 240.00	<input type="checkbox"/> 320.00
700.00	<input type="checkbox"/>	140.00	<input type="checkbox"/> 175.00	<input type="checkbox"/> 210.00	<input type="checkbox"/> 280.00
600.00	<input type="checkbox"/>	120.00	<input type="checkbox"/> 150.00	<input type="checkbox"/> 180.00	<input type="checkbox"/> 240.00
500.00	<input type="checkbox"/>	100.00	<input type="checkbox"/> 125.00	<input type="checkbox"/> 150.00	<input type="checkbox"/> 200.00
400.00	<input type="checkbox"/>	80.00	<input type="checkbox"/> 100.00	<input type="checkbox"/> 120.00	<input type="checkbox"/> 160.00
300.00	<input type="checkbox"/>	60.00	<input type="checkbox"/> 75.00	<input type="checkbox"/> 90.00	<input type="checkbox"/> 120.00
200.00	<input type="checkbox"/>	40.00	<input type="checkbox"/> 50.00	<input type="checkbox"/> 60.00	<input type="checkbox"/> 80.00

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The Month in Washington

The Public Health Service Advisory Committee on Immunization has concluded that routine typhoid fever vaccination is not needed any longer in the United States.

Surgeon General William H. Stewart accepted the findings of the committee and stated as PHS policy that immunization against the disease is not recommended on a routine basis.

The committee reported that the incidence of typhoid in this country had declined steadily for many years and now is less than 500 cases a year. A continuance of the downward trend was predicted.

The committee further stated that, "although typhoid vaccine has been suggested for individuals attending summer camps and those in areas where flooding has occurred, there are no data to support the continuation of these practices."

However, select immunization was recommended in the following situations:

—Intimate exposure to a known typhoid carrier as would occur with continued household contact.

—Community or institutional outbreaks of typhoid fever.

—Foreign travel to areas where typhoid fever is endemic.

In a separate report, the advisory committee predicted relatively little influenza during the 1966-67 season, but recommended vaccination after Sept. 1 for certain high-risk groups—such as the chronically ill and older persons.

The committee pointed out, however, that it is reasonable to expect that limited outbreaks of Type A₂ influenza will occur in parts of the United States not experiencing Type A disease in 1964-65 or 1965-66. Similarly, the possibility of some Type B influenza is recognized, particularly in the southwest.

"Vaccination when called for should begin as soon as practicable after September 1 and ideally should be completed by mid-

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December," the committee said. "It is important that immunization be carried out before influenza occurs in the immediate area since there is a two-week interval before development of antibodies."

Because variations in influenza viruses during the 1965-66 season were not of major significance, the composition of the 1966-67 vaccine is unchanged from that prepared for 1965-66.

* * *

A Senate Government Operations Subcommittee said that more information is needed in the field but that scientific data now available does not indicate human health hazards of sufficient significance to warrant drastic curbs on the use of pesticides.

However, the subcommittee reported that "the magnitude of the future risk is uncertain in many important areas."

"Knowledge regarding the risk of chemical pesticides . . . will have to be broadened and refined considerably in order to provide clear-cut answers to questions that will be forced by the increasing need for pest control in the future," said a subcommittee report based on a two-year study.

"While some of the more gloomy prophecies that had been raised could not be supported by hard scientific fact, it is also true that science could not and still cannot prove that some of these prophecies are untenable."

To combat the human health dangers, the report recommended that the Department of Health, Education and Welfare, accelerate an environmental health program; increased research in human pharmacology; development of non-chemical pest-control methods; training of agricultural workers in good hygiene practices in using pesticides; and general educational programs on health in the chemical age.

* * *

The Food and Nutrition Board of the National Academy of Science believes that it may be well for many Americans to moderately reduce the amount of fats they eat and substitute some polyunsaturated for saturated fats.

However, the board concluded in a lengthy report, "Dietary Fat and Human Health,"

that present evidence on the connection between dietary fat and cardiovascular diseases is insufficient to warrant recommendations for radical dietary changes.

The board's study was directed to the problem of how much and what kind of fat is compatible with human health. The report emphasized that any changes in consumption of fat should be made on an individual basis with consideration given the consequent changes in caloric and nutrient intake.

"Until we learn more about which fats are desirable nutritionally, the Board recommends that the American consumer should partake of the foods that make up a varied, adequate, and not overly rich diet and maintain a normal body weight by judicious control of caloric intake and by daily exercise," the report said.

* * *

The Social Security Administration said that the 460,000 medicare patients in hospitals during the first month of the program's operation did not result in any overcrowding.

There were a few isolated instances of overcrowding, mostly in rural areas, but they already existed before medicare started July 1, the SSA said.

The elderly patients occupied from 30 to 35 per cent of the beds in general hospitals, in comparison to about 25 per cent before medicare. Federal officials had estimated a 5 per cent increase.

Inquiries from intermediaries to SSA headquarters as to eligibility for Plan B medical benefits totalled 8700 through July 22. A few spot checks showed assignments leading over direct billings by a small margin. But assignments normally would be filed sooner than direct billings.

There still were about 200 hospitals in the south that had not been qualified as to civil rights requirements on racial integration. This situation left 132 counties that have hospitals with none qualified at the end of the month. By states, the counties were: Mississippi 31, Georgia 23, Louisiana (parishes) 19, Texas 12, Virginia 11, South Carolina 9, Alabama 8, Arkansas 6, Kentucky 6, North Carolina 3, Tennessee 2, Florida 2, and West Virginia 1.

Water pollution control activities of the federal government now are under the Interior Department.

The shift from the Department of Health Education and Welfare became official when Congress didn't veto President Johnson's reorganization request for the move. Johnson predicted the federal government "now is better organized to carry out concerted action against the pollution that blights America's waters."

Interior Secretary Stewart Udall promptly issued guidelines to the states for setting water quality standards designed "to make rivers as clean as possible," instead of "as clean as permissible."

Udall outlined the department's goal as a federal-state approach to assure a national supply of clean water necessary for health and economic growth.

Book Reviews

The New Way to Live with Diabetes. By Charles Wellser, M.D., and Richard Boylan. Illustrated by Howard S. Friedman. 144 pages. Price, \$3.95. Garden City, New York: Doubleday & Company, Inc., 1966.

Diabetes is the one disease where it is absolutely necessary that the patient know as much about the disease as his doctor does. In "The New Way to Live with Diabetes," a doctor collaborates with a feature writer to publish a practical guide to living with diabetes for the patient and his family.

The book outlines the three types of diabetes: insulin, overweight, and stress diabetes. It discusses the symptoms, detection, control, diet, exercise, the new drugs, traveling with diabetes, employment, getting insurance, and many other problems.

This book is designed to help diabetic patients get to know their disease and thus overcome the anxieties which many have regarding it.

* * *

New Drugs—1966. By the A.M.A. Council on Drugs. 584 pages. Price, \$4.00. Chicago: American Medical Association, 1966.

The first edition of this book was published in July, 1965. Over 30,000 copies were sold within the first six months and the AMA had to order two extra printings. The second (1966) edition has been enlarged and improved by the addition of five new chapters and 30 new drug monographs. Many of the individual drug evaluations have been revised, as have some of the general discussions which review the older drugs at the beginning of each chapter.

New Drugs contains individual monographs on 290 single-entity products that have been marketed in the

U. S. within the last ten years. Each monograph gives information on the drug's actions and uses; adverse reactions; contraindications or precautions; dosage and routes of administration; preparations and their available sizes and strengths.

These brief and clearly written statements provide the practicing physician with an independent and unbiased assessment of the more recently introduced drugs. The evaluations, which are based on a study of all the laboratory and clinical research data by the AMA's Council on Drugs and its consultants, will be of great assistance to the physician in the day to day conduct of his practice. Since a monograph on a drug is included whether or not the Council's opinion is favorable, **New Drugs** is in no sense a list of approved or accepted drugs. Drugs are indexed by their nonproprietary (generic) and trade names; Canadian trade name equivalents are also given.

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California Medical Career Openings: A limited number of openings available in all specialty areas including general medical practice. These openings are within The Permanente Medical Group leading in 3 years to a profit-sharing partnership. A representative of The Permanente Medical Group will hold interviews in Durham during the months of October or November 1966. For further information and interview appointment write or call I. M. Kalb, M.D., 3240 Arden Way, Sacramento, California, area code 916-482-8100. SO

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**NORTH CAROLINA
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September, 1966

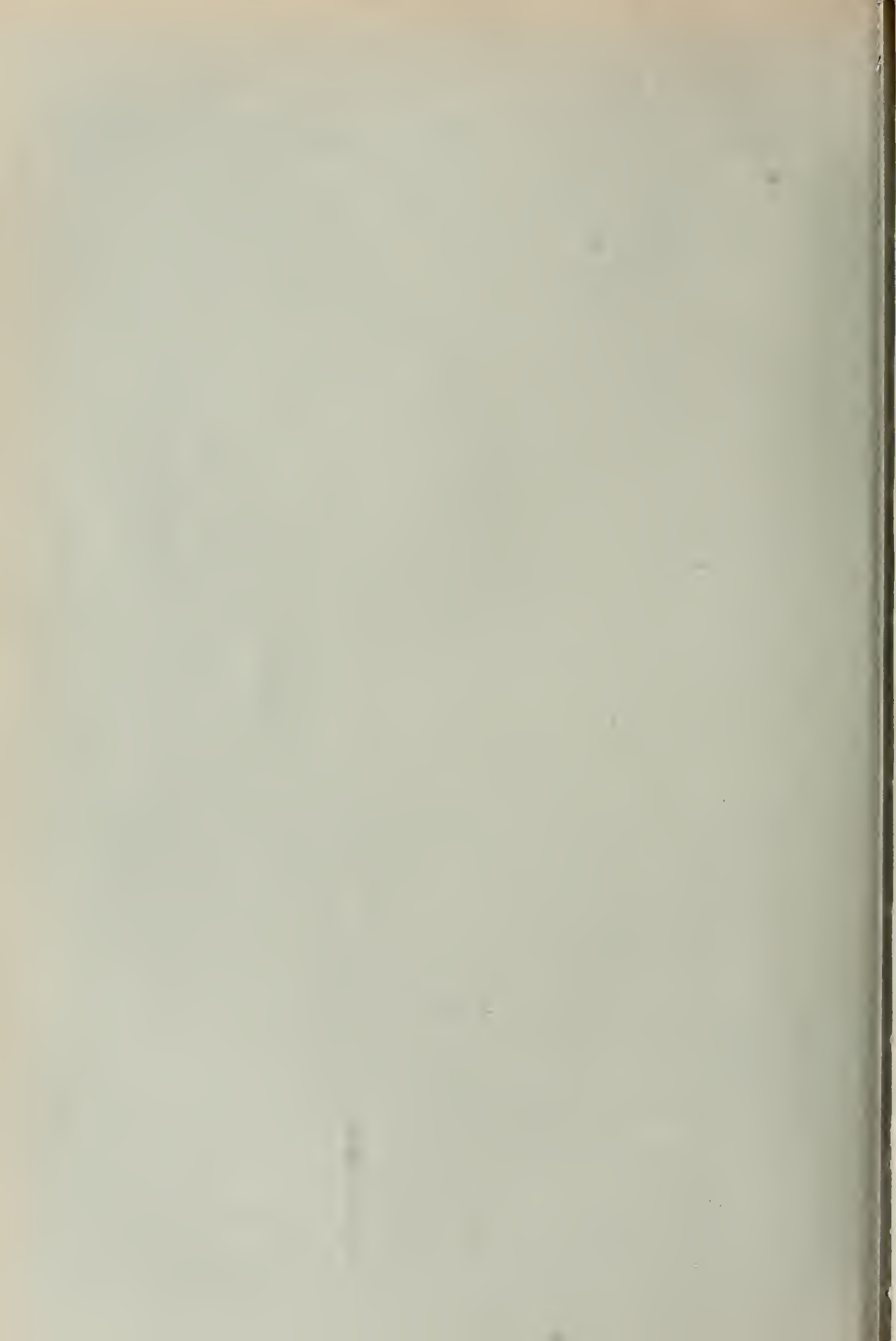
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held at
Asheville, North Carolina
April 30 - May 4, 1966

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1966
TRANSACTIONS
OF THE
MEDICAL SOCIETY
OF THE STATE OF NORTH CAROLINA

One Hundred Twelfth Annual Session

held at
Asheville, North Carolina
April 30-May 4, 1966

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1966 COMPILATIONS OF ANNUAL REPORTS

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1966 COMPILATIONS OF ANNUAL REPORTS

REPORT OF THE CONSTITUTIONAL SECRETARY

The enrolled membership in December 1965 was 3,572. This represents an increase in membership of 57 for the year. The resume of the meetings in September 1965 and January 1966 is recorded in the transactions. The large number of physicians and wives who made their way to Pinehurst through very severe weather in January attests to the interest in the activities of the society.

The constitutional officers attended the annual meeting in New York, and the interim meeting in Philadelphia of the American Medical Association. The American Medical Association through its membership is vigorously studying and in the process of aiding in implementation of Public Law 89-97 (Medicare). Each physician engaged in his profession, whether a member of the American Medical Association or not, will be deeply involved in the problems of the new public law.

No significant change has been made in the format for the annual meeting in Asheville in 1966.

Committee chairmen and members have pursued assignments with interest and energy, and have shown great ability in the various assignments.

The extensive work of the Medical Society in all facets of our state activity bearing on medicine is shown by the large number of committees and the reports contained in the compilation presented here.

The Headquarters office has continued to function well in a fiscally sound manner. The Executive Director and his staff have rendered outstanding service to the membership of the Society.

Charles W. Styron, M.D., Secretary

REPORT OF THE EXECUTIVE DIRECTOR

Mr. Speaker, President Paschal, Members of the House of Delegates, distinguished guests, friends and staff associates.

The Greek Lucanus to be known as Luke, the Physician, at the threshold of his practice career, when he had completed his medical education at Alexandria, first visited his mother in Rome and while contemplating his career, sophisticated that "Rome is already lost." To this Keptah, his original preceptor observed, "Man is his own executioner, he is his own disease, his own fate, his own death. His civilizations are an expression of him." This bit of comment related to an ancient history is of a peculiar interest now. Historically this was the moment at which the Christian era was to become founded and connotative of profound change in man's attitudes throughout the world and vasilatingly throughout time.

If any thing has characterized the past year in medicine and professional organization, I suppose

the simple word, "change," describes it. What began in early 1965 must have seemed to many as routine—just "par for the course." To others the year 1964 did offer evidence of forebodings, despite good strength and progress throughout most levels of medical activity in its science and the ever practiced concern for the public health and the public good. To most of us, the good effort at the education of the leadership of the Society toward responsibility to persuasion in related areas of activity, particularly in government, seem to have been properly implemented and to have been productive of much and useful understanding for our medical way of life and in protection of our great achievements in this last half-century. We know our efforts were good and our intentions proper. North Carolina representation in the U. S. Congress understood our problems, our goals and the portents of our seekings—they stood with us completely on the issues. This achievement was unique to North Carolina for no other state of any delegate size has attained this good consideration, which came about from good educational efforts within the profession with allies and with those responsible for our representation in government. Assuredly this was achieved after much effort and sacrifice of time on the part of your leadership and of your Society's staff and indeed the membership.

But "change" appears to have been the order of the day to follow the 1964 avalanche; so all professional effort and organizational effort went beside-the-point in the waning weeks of the first session of the 89th Congress, when Public Law 89-97 (Medicare) became a fact for future concern, for future effort and for future action on multiply involved policy, procedure and public regulation. 'There is change! What lies in the future is difficult to foretell, but that it will require different tactics, different techniques and a different attitude may well be predicted.

As one looks backward over the passing two decades, achievements in sound medical planning in the sciences and achievements in medical care, one can note progress and success. What prevailed in 1947, marking my first assignments with the Society, is a far better product today; that we all know. Yet, these accomplishments appear not enough and through political action we are now confronted with vast changes which will require reckoning as we go each step of the way down a course of charge, perhaps directly to marked socialization. We are now involved in a thrash of terminology carrying connotations of we know not what, nor most know how and in what directions they will lead us. There are such things as "guidelines" which may or may not guide; there are "criteria" which cry out for lack of meaning and which purport confusion; there are "reasonable" which may or may not imply reason and rather im-

ply the strong will of men, mostly non-medical; there are the "customary" without asking the custodian of the custom; there is "prevailings" which ominously do not seem to prevail except in individual and regulatory concepts; there are "rules" which partend to do that or ruin; there are "regulations" written often in haste and with little regard to the regulated and what the regulated's part should be; there are "advisory" bodies which may find lessened opportunity to advise and whose advice may be loosely and ineptly applied; there are "carriers" which may carry in a single direction without benefit of the justice of a two way concern; there are "intermediaries" which may overlap carriers and add to the confusion and intermediate in silence; there are printing, releases, memoranda, brochures, documents, forms all designed to make inroads on the health care of the people in terms of scare medical effort—these appear ad infinitum; and, there are doctors who are scarcely consulted, at least through the ten months since the enactment of Public Law 89-97, at least in our state. These things, I am sure, will arise to haunt you in the months and the years to come.

So what does one do? One can sense strength in unity; power in knowledge; usefulness in techniques and knowledge from communication, study and work at the problem. There is no value in abandonment; there is no service in wonderment; there is a job to do that will not be accomplished by pettiness, useless bickering and fear, least of all the latter. Maintain your Society, bring to it wide participation and leadership, yes and a bit fellowship. Support it with your resources and your time while you have both, for without this attitude your profession is in great trouble as evidences pile up in every nation where this sort of movement has gained a footing. Now should be the moment to stand on principles which have gained meaning and value over the years—not only to you as doctors but to the people you serve. With it all, be gracious—perhaps play your hand next to God—not playing God. Attention to fidelity would seem now a first premise.

Anent the above expressions, I must assent my good faith in medicine, nor have my own tenets of humility become upset from the basis of those set now twenty years ago when I became to consider your assignments of staff undertakings. But my overview is larger and, I hope, more meaningful. My span of service encompasses great leaders you have produced, useful program, and efforts they and your intercurrent leaders have devised. And while we have shown progress I still embrace humility as a grace and a way of life which joined with real doctor leadership may show us a way forward.

In presenting this report of your staff productivity for the past year, I sense a full heartiness in the leadership invested in your Executive Council particularly your president George Paschal and

the councilors, which with the elected officials, constitute this interm body of action and authority. It has met frequent necessity for added and special effort. Time, one is sure, will reflect the wisdom and rightness of its decisions and actions. They have always been respectful of the professional and public needs. Especially has this been a pleasant year in working with President Paschal. No leader of the Medical Society has given greater amounts of talent and time and resource to further the work of this great organization and history will tell of his astuteness, knowledge and effort—perhaps with emphasis upon the good judgement and good heart which ever motivates him and which he has exercised in carrying on these many years of services culminating in his Presidency and leadership yet to be contributed, both at the state and national level. To me, to travel and converse, and plan and carry out his decisions has been one of the finest experiences and I shall treasure his complete fellowship on every course we have sailed. I hope he has no sense that these courses have not led the profession and the Society to complete levels of security and soundness for future events. One feels that he has been right and that right and justness will prevail in the end, though our misgiving at events do disturb us at this moment.

Most of you who have studied the record know the growth of the Society and its activity. In these the staff has been fully engaged. Health and strength, some accrued know-how, has brought us through the difficult and sometimes, disappointing days of this era. Though at the threshold, where many men gain and respite, I have never worked harder and with more difficulty of attainment. So has the full staff. We go on to another day and to another year and era with determination. With you we shall always seek what is first for the public good and find ways and means by which the profession may safeguard, protect and project the public goal. We shall accomplish despite seeming impediments which for the moment seem difficult to overcome. Comparably, your Society begs no merit enjoyed in others. Of this comparison, made over and over, the staff takes pride. We believe understandingly you do.

President Paschal gave great and personal thought to the committee structure which may be said to be the heart of the Society's anticipations, concerns and actions. As you will have noted in the Compilation of Reports good works have been in the course and cause of the Society this year, President Paschal deserves the thanks of the Society for his wise and useful choices—and for the stimulation which committee activity received from him throughout their courses. Their accomplishments are good, useful and important.

During the fall we employed Mr. Bryant Paris, representing the first substantial staff addition in 12 years. He has gone through orientations and

increasingly is being assigned activities which we note to be assumed with due diligence and determination. We predict his youthfulness and good background will in fair measure offset superannuation which will become a factor as the years transpire. Mr. Paris' voluntary efforts to the PAC leadership has been effective. Other useful work is planned for his efforts and growth will attend the coming year.

The Fall Conclave as well as the County Officers Conference were marked successes as evaluated by officials and visitors. Both of these devices enhance the educational and functional activity of the Society and one recommends their continued usefulness and support. Committee activity through the year has been at a markedly higher level and the work of the Society has been generously enhanced by these efforts of the committee leadership and participants. The staff has fully participated in these efforts throughout the year with evidence of growth and capacity. Particular mention in these capacities should be made of Mr. Wm Hilliard, Miss Kay Ziegler, Mr. Garland Pace, Mrs. LaRue King, each of whom has shown aptitude, interest, fellowship and effectiveness in implementation related to committee activity and procedure.

Fiscally the Society is sound and shows progress. The audit very well supports this showing of no deficits, despite tax problems related to employment security which has been contributed in protest based on 1951-52 adjudications. The operation for 1965 indicates a net accretment in the Society favor. Meanwhile the reserves and investments are remarkable as to future and useful objectives of the Society. These too are sound and show growth.

The North Carolina Medical Journal is on a straight and sound course as to production and quality. It's fiscal conditions have markedly improved and we predict recovery in advertisal support to the point of self carry, perhaps in the not distant future. Continuing effort is made daily in this direction. Our efforts at January 1, 1966 in transferring the printing to a more favorable contract has helped in both quality and fiscal production—economy. The exhibit program is at a high level of participation and fiscal gain.

Finally, I express appreciation to the officers, to the committees, to the Executive Council, to the new Executive Committee (created last year by the House of Delegates) and to the membership of the Society for the clarity and the excellence of directions which attend our assignments and activities during the transpired year and to beg for equal clarity and direction in the difficult months to come. Only by such unity can the Staff best serve the interest of the Society in these changing times, which are sure to be difficult at best. Only so can confusion and dissention be avoided. This seems important in the era which the profession and the Society representing it, faces in these

serious times. Do be patient when we mingle with the unknown and particular the oppressiveness of influences the portents of which few know at this hour. Do evaluate us always and aid us seek the best and the most secure productive level of operations. This applies likewise to our new efforts at state-wide billing of dues which has shown a marked success both in effectiveness and clarity and efficiency during this first year of experience. We are convinced this is an acceptable method and will become increasingly so.

We continue our sense that we serve you well by intent and by application of good determinations and in so doing we serve the public too. And then, we repeat our thankfulness to the kindest Providence which makes it possible that we serve and serve knowledgeable and well, recognizing that this spiritual support does sustain, as it has through the years, leading along to blessings which we count and you can count as of import in all the accomplishments of men and this Society in particular.

Statistical Report of Headquarters Activity*

1965-1966

Processable mail received	20,240
Mail dispatched	54,981
Telephone communications	5,521
Telegram communications:	
Regular outlet	279
TWX outlet	152
Transmittals of documentary material	783
Reports	1,653
Meetings attended and participated	342
Personal conferences	233
Review of literature (related)	472
Talks (staff)	24
Transaction disseminations	82

*Except for telephone and telegraphic communications this data is not inclusive of nor duplicates the data submitted in report of the Assistant Executive Director.

James T. Barnes
Executive Director
Medical Society of the
State of North Carolina

Raleigh, N. C.
April 12, 1966

Attached hereto and filed with the Official Reporter of the Society is the original copy of the 1966 Audit Report of A. T. Allen & Company, Certified Public Accountants of Raleigh, North Carolina for the fiscal period January 1, 1965 to December 31, 1965 which bears the Auditors date of January 24, 1966.

AUDITOR'S REPORT

Medical Society of the State of North Carolina, Incorporated
Raleigh, North Carolina

12 Months Ended December 31, 1965

OFFICERS

Dr. George W. Paschal, President	Raleigh, N. C.
Dr. Frank W. Jones, President-Elect	Newton, N. C.
Dr. Theodore S. Raiford, Past President	Asheville, N. C.
Dr. W. Otis Duck, First Vice-President	Mars Hill, N. C.
Dr. John J. McCain, Second Vice-President	Wilson, N. C.
Dr. Charles W. Styron, Secretary	Raleigh, N. C.
Dr. Donald B. Koonce, Speaker of the House	Wilmington, N. C.
Dr. Robert L. Garrard, Vice Speaker of the House	Greensboro, N. C.
Mr. James T. Barnes, Executive Director	Raleigh, N. C.

Chairman and Members of the Finance Committee
Medical Society of the State of North Carolina,
Inc.

Raleigh, North Carolina

Gentlemen:

Pursuant to engagement, we have audited the books and records of the Medical Society of the State of North Carolina, Inc., Raleigh, North Carolina, for the period beginning January 1, 1965, and ending December 31, 1965, and present herewith our report.

Exhibits and Schedules

In presenting to you our findings, as the result of the audit, we have prepared four Exhibits and three Schedules, as outlined in the Index, which are attached hereto as a part of this report.

Balance Sheet—Exhibit "A":

The first statement is a list of the Assets, Liabilities, Reserves and Fund Balances, which we designate as Balance Sheet, December 31, 1965, Exhibit "A." This statement has been divided into two sections. One contains the Current Operating Fund, which represents the Current Assets, Liabilities and Reserves. The other has been designated as a Capital or Non-Operating Fund containing the office equipment, real estate and capital stock owned and used by the Medical Society—at estimated values established in a prior year plus actual cost for purchases during the last several years.

The Cash on Hand and in Bank is made up of \$50.00 Petty Cash Fund and \$141,792.38 in the First-Citizens Bank and Trust Company, Raleigh, North Carolina. The Cash in Bank was verified through a reconciliation of the balances as shown by the records of the Medical Society with a certificate which was obtained independently from the bank. This reconciliation is shown in detail in Schedule - 1 of this report.

Accounts Receivable - Regular in the amount of \$2,469.61 are shown on the Balance Sheet. The balance represents the total of several uncollected balances due for local advertising in the State

Medical Journal.

Accounts Receivable - National Advertising in the amount of \$5,305.15 represent November and December, 1965, National Advertising in the State Medical Journal. These amounts were confirmed directly with the State Medical Journal Advertising Bureau. The November amount was received in January, 1966.

Prepaid Expenses and Supplies in the amount of \$750.31 represent Expenses paid prior to December 31, 1965, but applicable to the operations of the year 1966.

Air Travel Deposit of \$425.00 is cash deposited with Eastern Airlines in order to secure air travel credit cards.

The investment in Investors Mutual, Inc., stock is shown at cost value of \$140,844.28. This represents the cost of 12,863.962 shares held December 31, 1965. During 1965 723.263 shares were reinvested from dividends earned in the amount of \$8,854.35. The value of this investment at December 31, 1965, was \$12.36 per share (bid price), or a total of \$158,998.57.

The real estate, capital stock and office equipment and furniture shown on the Balance Sheet in the amount of \$64,969.86 is listed in detail in Schedule - 2. This represents an estimate made in a prior year which has been adjusted for purchases made during the last fourteen years. The items shown represent cost value of the equipment to the Medical Society as no depreciation has been recorded. As there were no liabilities outstanding against this equipment, we have shown the entire amount as Fund Balances - Capital Fund - in the Balance Sheet.

Under the "Liabilities" section we have listed those accounts, expenses, etc., incurred prior to December 31, 1965, for which statements or accounts were rendered or for which payment was due.

The Accounts Payable - Trade, in the amount of \$16,453.14 represents unpaid accounts at December 31, 1965. These unpaid accounts are for Journal publication, \$3,280.00, legal fees, \$7,734.60 and

other expense, \$5,438.54. Most of these items were paid during the course of the audit.

The \$926.00, Dues to be Refunded, represents State dues collected which have refundable to the members. The \$29,322.50, "Due American Medical Association," in 1966 A. M. A. dues collected in 1965. The \$825.00, "American Medical Association Dues In Escrow," represents dues paid to the State Society but which cannot be remitted to the National Society at the time due to diverse disqualifying reasons. At December 31, 1965, the Society had collected from members \$7,275.00 for MEDPAC contributions and \$12,326.00 for county dues. These items will be remitted to the respective organization in regular course. The payroll taxes, \$185.32, for the Society's Social Security and \$1,393.25 for employees' Social Security and Withholding, were paid during the course of the audit.

The deferred credits of \$52,645.00 are for payments of \$4,460.00 received on technical exhibits space at the 1966 Convention, \$585.00 on 1966 Convention Banquet, and \$47,600.00 on 1966 membership dues. These remittances were received in 1965 and will be transferred to the income accounts in 1966.

The Reserve for Mental Hygiene of \$5,000.00 is a reserve to cover expenses and costs of the said committee in its rehabilitation work.

The Reserve for Medical Building Site represents the unexpended portion of the \$30,723.00 received from the sale of Sereis "F" bonds. The expended portion of this fund is \$26,104.55 and is set out in Schedule - 3 of this report. This leaves a balance of \$4,618.45 not disbursed to date.

The Fund Balance section of the Balance Sheet is comprised of two figures, \$160,667.07 being the balance of the Current Operating Fund for the year, and \$64,969.86 representing the balance of Capital Fund.

Statement of Fund Balances—Exhibit "B":

The second statement is an analysis of the changes in Fund Balances during the year.

The Current Operating Fund Balance was arrived at by adding to the balance January 1, 1965, of \$121,704.94, the excess revenue over expenses of \$37,603.42, the amount of dividends from investments used to purchase additional shares of \$8,854.35, closing the old balance from the Raymond Randolph Scholarship Fund of \$280.00; and subtracting the expenditures for Capital Fund, \$7,775.64; leaving a balance of \$160,667.07 at December 31, 1965.

The Capital Fund Balance increased during the year from \$57,624.81 to \$64,969.86. This increase represents the excess of purchases made during this period of \$7,775.64 from operating funds over the equipment traded on these purchase of \$430.59. Included in this amount is a \$5,000.00 option on real estate which will expire May 30, 1966, if the option is not exercised.

Statement of Income and Expenses—Exhibit "C":

A statement showing a budget comparison of the income and expenses for the twelve-months period is given in Exhibit "C." This statement is, in effect, a statement of operations for the year, and by examination it will be seen that the Income of \$294,936.88 exceeded the Expenses of \$265,109.10 by \$29,827.78. There was included in the expenses \$2,775.64 in Capital Expenditures for Equipment and \$5,000.00 for the purchase of an option on real estate. Eliminating these we show income from operations of \$37,603.42.

In comparison with the Budget, actual income was more than the Budget anticipated by \$10,591.88. The main items accounting for this are \$3,056.00 more from Membership Dues, \$5,595.44 contributions earmarked for mental health and \$1,319.03 more from Local Journal Advertising; \$2,479.84 more from National Journal Advertising, \$2,070.00 less from Sale of Banquet tickets and \$1,100.00 less from sale of Exhibit space.

Further examination reveals that the total actual expenses were \$9,844.10 more than the budget provision. The Miscellaneous Budget had over-expenditures of \$20,928.06 while all other budget classifications show under-expenditures for the year, or were within a reasonable expectation of the budget. It should be noted that \$15,218.83 was paid out of the miscellaneous budget to the Internal Revenue Service for Federal Unemployment Taxes paid under protest. Also \$5,000.00 was spent for the purchase of an option to purchase real estate, and \$1,000.00 was advanced to the Medical Education Political Action Committee as a contribution. **Cash Receipts and Disbursements—Exhibit "D":**

A statement showing in detail the cash receipts and disbursements of the Society during the year under review is shown in Exhibit "D" which we summarize as follows:

Cash Balance January 1, 1965	\$ 9,626.28
Cash Receipts During the Year	554,051.40
Total Cash Available	\$563,677.68
Less:	
Disbursements During the Year:	
For Operations	\$275,048.83
To A. M. A. - Dues	139,545.00
For Capital Expenditures	7,241.47
	421,835.30
Cash Balance December 31, 1965	\$141,852.38

We made a careful analysis of the cash transactions and, where practicable, traced the receipts to their original source. Disbursements for expenses were supported by cancelled checks and invoices issued in the regular course of business. We believe the funds have all been accounted for.

General Comments

A surety bond covering faithful performance of Mr. James T. Barnes, Executive Director, in the

amount of \$50,000.00, is in force, held by the Medical Society and was examined by us. We also examined and found in force a Primary Commercial Blanket Honesty Bond in the amount of \$25,000.00; a fire insurance policy - with 80% co-insurance clause - covering fire loss on office equipment, books and records in the office of the Executive Director, Raleigh, North Carolina, in the amount of \$20,000.00; an Automobile Schedule Policy; a Standard Workmen's Compensation and Employer's Liability Policy; and a Comprehensive General Liability Policy.

We were extended every courtesy and cooperation during the course of the audit and we experienced no trouble in obtaining the necessary information for this report.

Scope of Examination and Opinion

We have examined the balance sheet of the Medical Society of the State of North Carolina, Incorporated, as of December 31, 1965, and the related statements of income and expense and fund balances for the year then ended. Our examination was made in accordance with generally accepted auditing standards, and accordingly included such tests of the accounting records and such other auditing procedures as we considered necessary in the circumstances.

In our opinion, the accompanying balance sheet and statements of income and expense and fund balances present fairly the financial position of the Medical Society of the State of North Carolina, Incorporated, at December 31, 1965, and the results of its operations for the year then ended, in conformity with generally accepted accounting principles for non-profit organizations applied on a basis consistent with that of the preceding year.

Very truly yours,

A. T. ALLEN & COMPANY

CERTIFIED PUBLIC ACCOUNTANTS

By: A. T. Allen

Certified Public Accountant

(SEAL)

Raleigh, N. C.

January 24, 1966

Medical Society of the State of North Carolina,
Incorporated
Raleigh, North Carolina

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SCHEDULES

Cash on Hand and In BankSchedule - 1
Schedule of Capital AssetsSchedule - 2
Schedule of Building Site CostsSchedule - 3

EXHIBIT "A" - BALANCE SHEET December 31, 1965

ASSETS

CURRENT OPERATING FUND:

Cash on Hand and In Banks (Schedule - 1)	\$141,842.38
Accounts Receivable - Regular	2,469.61
Accounts Receivable - National Advertising	5,305.15
Prepaid Expenses and Supplies	750.31
Air Travel Deposit	425.00
Investment in Mutual Fund Stocks	140,844.28

TOTAL CURRENT OPERATING FUND \$291,636.73

CAPITAL OR NON-OPERATING FUND - (SCHEDULE - 2)

Real Estate	\$ 26,104.55
Office Furniture and Fixtures	33,665.31
Capital Stock, Common - State Medical Journal Advertising Bureau	200.00
Option to Purchase Real Estate	5,000.00

**TOTAL CAPITAL OR
NON-OPERATING FUND** 64,969.86

TOTAL ASSETS \$356,606.59

LIABILITIES, RESERVES AND NET WORTH:

LIABILITIES:

Accounts Payable - Trade	\$ 16,453.14
Dues to Be Refunded	926.00
Due American Medical Association - Dues Collected	29,322.50
Due American Medical Association - Dues In Escrow	825.00
Due to Medical Education Political Action Committee (MEDPAC)	7,275.00
Due to Counties - Dues Collected	12,326.00
Federal and State Income Tax Withheld	1,393.25
Pay Roll Taxes Payable	185.32

TOTAL LIABILITIES \$ 68,706.21

DEFERRED CREDITS:

Advance Payments on Technical Exhibit	\$ 4,460.00
Advance Payments on 1966 Convention Banquet	585.00
Advance Payment on 1966 State Membership Dues	47,600.00

TOTAL DEFERRED CREDITS \$ 52,645.00

RESERVES:

Reserve for Mental Hygiene Committee	\$ 5,000.00
Reserve for Medical Building Site	4,618.45

TOTAL RESERVES \$ 9,618.45

FUND BALANCES:

Current Operating Fund (Exhibit "B")	\$160,667.07
Capital Fund (Exhibit "B")	64,969.86

TOTAL FUND BALANCES 225,636.93

**TOTAL LIABILITIES, RESERVES AND
NET WORTH** \$356,606.59

EXHIBIT "B"

STATEMENT OF FUND BALANCES

December 31, 1965

CURRENT OPERATING FUND:

Balance-January 1, 1965	\$121,704.94
ADD: Income in Excess of Expenditures	\$37,603.42
Increase in Investment—Dividends on Stock of Investors Mutual, Inc., Used to Purchase Addition- al Shares	8,854.35
Old Reserve Account Closed Out	280.00
TOTAL	168,442.71
LESS: Expenditures for Capital Fund	7,775.64
TOTAL CURRENT OPERATING FUND—TO EXHIBIT "A"	\$160,667.07

CAPITAL FUND:

Balance—January 1, 1965	\$ 57,624.81
ADD: Purchases Made Through Current Fund	7,775.64
TOTAL	\$ 65,400.45
LESS: Items Traded on New Assets	430.59
TOTAL CAPITAL FUND—TO EXHIBIT "A"	64,969.86

TOTAL FUND BALANCES—	
DECEMBER 31, 1965	\$225,636.93

EXHIBIT "C"
STATEMENT OF INCOME AND EXPENSES
 12 Months Ended December 31, 1965

	Budget Provision	Actual	Difference Over or (Under)
INCOME:			
Membership Dues—Current and Prior Years	\$219,800.00	\$222,856.00	\$ 3,056.00
Sales of Journals, Rosters and Value Scales	1,500.00	2,372.21	872.21
Author Contributions To Cuts	250.00	202.41	(47.59)
Revenue Unexpected	400.00	880.87	480.87
Sales of Technical Exhibit Space	21,000.00	19,900.00	(1,000.00)
Journal Advertising—Local	8,000.00	9,319.03	1,319.03
Journal Advertising—National	25,000.00	27,479.84	2,479.84
Commission (1%) from AMA for Dues Collected	1,395.00	1,401.08	6.08
Ticket Sales—1965 Convention Banquet	7,000.00	4,930.00	(2,070.00)
Contribution Earmarked for Committee on Mental Health	—0—	5,595.44	5,595.44
TOTAL INCOME	\$284,345.00	\$294,936.88	\$ 10,591.88
EXPENSES:			
Executive Budget:			
A-1 Expense—President	\$ 6,000.00	\$ 4,492.54	\$(1,507.46)
A-3 Travel—Secretary	1,000.00	580.73	(419.27)
A-4 Salary—Executive Director	18,000.00	18,000.00	—0—
A-5 Travel—Executive Director	5,000.00	5,000.00	—0—
A-6 Clerical Assistants—Office	32,000.00	33,080.61	1,080.61
A-7 Equipment—Office	3,000	2,643.55	(356.45)
A-8 Expenses—Office	12,240.00	13,298.21	1,058.21
A-9 Bonding (In Effect to 1966)	—0—	—0—	—0—
A-10 Auditing	700.00	760.00	60.00
A-11 Pay Roll Taxes	1,685.00	1,602.86	(82.14)
A-12 Insurance	293.00	262.89	(30.11)
A-13 Membership Record System	100.00	70.87	(29.13)
A-14 Publications, Reports and Executive Aids	200.00	140.05	(59.95)
A-15 Insurable: Interest Insurance and Retirement Plan	1,371.00	5,295.30	3,924.30
A-16 Salary—Assistant Executive Secretary	11,100.00	11,100.00	—0—
A-17 Salary—Rural Health Consultant	5,772.00	5,772.00	—0—
A-18 Travel—Assistant Executive Secretary	2,400.00	1,846.17	(553.83)
A-19 Travel—Rural Health Consultant	2,000.00	1,713.63	(286.32)
Total Executive Budget	\$102,861.00	\$105,659.46	\$ 2,798.46
Journal Budget:			
B-1 Publication of Journal	\$ 38,000.00	\$ 37,972.65	\$(27.35)
B-2 Cuts for Journal	500.00	672.95	172.95

B-3 Salary—Editor	2,310.00	2,310.00	—0—
B-4 Salary—Assistant Editor	4,680.00	4,680.00	—0—
B-5 Expenses—Editorial Office	450.00	343.91	(106.09)
B-6 Expenses—Business Manager's Office	450.00	399.47	(50.53)
B-7 Equipment—Business Manager's Office	100.00	31.52	(68.48)
B-8 Travel for Journal	200.00	172.90	(27.10)
B-9 Pay Roll Taxes	266.00	253.44	(12.56)
B-10 Sales Tax on Journal and Roster Sales	500.00	497.54	(2.46)
B-11 Publication of Roster	4,500.00	5,382.77	882.77
B-12 Expense—Executive Council Reports	10,000.00	6,016.39	(3,983.61)

Total Journal Budget	\$ 61,956.00	\$ 58,733.54	\$(3,222.46)
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Intra-Function Activity Budget:

C-1 Expenses—Executive Council	\$ 2,500.00	\$ 1,719.42	\$(780.58)
C-3 Expenses—Legislative Committees	6,000.00	4,154.96	(1,845.04)
C-4 Expenses—Maternal Health Committee	3,600.00	3,611.04	11.04
C-7 Expenses—Scientific Exhibits Committee	675.00	83.96	(591.04)
C-8 Expenses—Mental Health Committee	500.00	2,913.77	2,413.77
C-9 Expenses—Grievances Committee	200.00	—0—	(200.00)
C-10 Expenses—Chronic Illness Committee	2,000.00	1,559.83	(440.17)
C-11 Expenses—Committees in General	2,500.00	2,956.86	456.86
C-13 Expenses—Occupational Health			
C-16 Expenses—Negotiations Committee	2,000	4.45	(195.55)
C-17 Expenses—Student AMA Committee	250.00	—0—	(250.00)
C-18 Expenses—Disaster Medical Care Committee	1,426.00	1,296.20	(129.80)
C-19 Expenses—Industrial Commission	500.00	395.96	(104.04)
C-20 Expenses—Constitution and By-Laws Committee	100.00	—0—	(100.00)
C-21 Expenses—Medical Legal Committee	—0—	—0—	—0—
C-22 Expenses—Traffic Safety Committee	100.00	10.30	(89.70)
C-23 Expenses—Venereal Disease Committee	100.00	7.07	(92.93)
C-24 Expenses—Anesthesia Study Committee	150.00	—0—	(150.00)
C-26 Expenses—Blue Shield Committee	400.00	400.00	—0—
C-27 Expenses—School Health Committee	250.00	1.73	(248.27)
C-28 Expenses—N. C. Board of Public Welfare Advisory Committee	400.00	120.05	(279.95)
C-30 Expenses—Insurance Industry Liaison Committee	100.00	11.74	(88.26)
Intra-Functional Activity Budget:			
C-31 Expenses—Rural Health Function	500.00	6.26	(493.74)
C-32 Expenses—Relative Value Schedule Committee	\$ 800.00	\$ 778.48	\$(21.52)
C-33 Expenses—Liaison to N. C. Pharmacy Association Committee	100.00	1,603.85	1,503.85
Total Intra-Functional Activity Budget	\$ 23,601.00	\$ 21,635.93	\$(1,965.07)

Extra Functional Activities Budget:

D-1 Expenses—Delegates to AMA	\$ 2,018.00	\$ 3,789.21	\$(1,771.21)
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D-2 Conference Dues	200.00	257.50	57.50
D-3 Woman's Auxiliary	2,800.00	2,246.93	(553.07)
<hr/>			
Total Extra Functional Activities Budget	\$ 5,018.00	\$ 6,293.64	\$ 1,275.64
E-3 Committee Chairman, Out of State Travel	\$ 500.00	\$ 191.35	\$(308.65)
E-5 Equipment	1,250.00	100.57	(1,149.43)
E-6 Expenses, Office	5,000.00	5,442.48	442.48
E-8 Publications and Executive Aids	100.00	129.81	29.81
E-10 Educational Distributions	800.00	147.42	(652.58)
E-11 News and Press Releases	400.00	312.39	(87.61)
E-12 Public Relations Bulletin	2,700.00	2,359.17	(340.83)
E-13 State High School Science Fair Programs	200.00	178.13	(21.87)
E-14 Exhibits and Displays	650.00	676.82	26.82
E-15 Annual Officers Conference	1,000.00	1,079.02	79.02
E-16 Physicians Press Award	—0—	—0—	
E-17 Pubic and Personified Activities	600.00	694.00	94.00
E-18 Collateral Public Relations	500.00	238.04	(261.96)
<hr/>			
Total Public Relations Budget	\$ 14,000.00	\$ 11,591.48	\$(2,408.52)
Annual Sessions (111th) Convention Budget:			
F-1 Programs	\$ 1,750.00	\$ 1,613.72	\$(136.28)
F-2 Hotel and Auditorium Expense	5,200.00	5,208.43	8.43
F-3 Expenses—Publicity Promotion	700.00	288.70	(411.30)
F-4 Entertainment	900.00	969.55	69.55
F-5 Orchestra and Floor Entertainment	2,500.00	1,751.89	(748.11)
F-6 Guest Speakers	1,000.00	879.54	(120.46)
F-7 Banquet Speaker	550.00	500.00	(50.00)
F-8 Electric Amplification	250.00	25.32	(224.68)
F-9 Booth Installation and Supplies	6,000.00	5,030.86	(969.14)
E-9 Audio-Visual Depiction	300.00	42.28	(257.72)
F-10 Projection Expense	700.00	837.76	137.76
F-11 Badges	150.00	31.64	(118.36)
F-12 Transactions Reporting Service	1,400.00	1,279.36	(120.64)
F-13 Rental - Extra Facilities	250.00	190.59	(59.41)
F-1 Exhibitors Entertainment	3,000.00	858.80	(2,141.20)
F-15 Banquet Expense	6,500.00	3,781.33	(2,718.67)
F-16 Police Security	312.00	352.50	40.50
Total Annual Sessions (111th) Convention Budget	\$ 31,162.00	\$ 23,599.99	\$(7,562.01)
Miscellaneous Budget:			
G-1 Legal Counsel	\$ 7,000.00	\$ 7,973.20	\$ 973.20
G-2 Reporting (Executive Council, Etc.)	1,700.00	2,026.34	326.34
G-3 Fifty Year Club	185.00	181.55	(3.45)
G-4 Contingency and Emergency	1,500.00	21,510.58	20,010.58
G-5 Employees Retirement System	4,282.00	4,845.77	563.77
G-6 Advalorem Taxes	325.00	315.91	(9.09)
G-7 Association of Professions Loan	350.00	200.00	(150.00)
G-8 N. C. Hospital Association Recruitment Program	500.00	500.00	-0-
G-9 Association of American Medical Colleges	225.00	-0-	(225.00)
G-10 Expense of Commissioners	600.00	41.71	(558.29)
<hr/>			
Total Miscellaneous Budget	\$ 16,667.00	\$ 37,595.06	\$ 20,928.06)
TOTAL EXPENSES	\$255,265.00	\$265,109.10	\$ 9,844.10

SUMMARY	
TOTAL INCOME	\$294,936.88
Less: Expenses:	
Executive Budget	\$105,659.46
Journal Budget	58,733.54
Intra-Functional Activity Budget	21,635.93
Extra Functional	
Activities Budget	6,293.64
Public Relations Budget	11,591.48
Annual Sessions (111th)	
Convention Budget	23,599.99
Miscellaneous Budget	37,595.06
	265,109.10
EXCESS OF INCOME OVER EXPENSES	\$ 29,827.78
Add: Capital Expenditures From Current Funds	7,775.64
Net Margin From Operations	\$ 37,603.42

Exhibit "D"

RECEIPTS:

Members' Dues — Current and Prior Years	
And Advance Dues	\$269,856.00
Medical Journal Advertising—	
Local	10,121.97
Medical Journal Advertising—	
National	27,133.68
Sale of Exhibit Space—	
1965 Convention	16,515.00
Sale of Exhibit Space—	
1966 Convention	4,460.00
Medical Journal Subscriptions and	
Sales of Rosters and Value Scales	2,285.51
Author's Contributions to Cost	
of Cuts	169.15
Commission (1%) from AMA for	
Collecting National Dues	1,401.08
Unexpected Revenue	708.80
Reimbursements for Items Paid	
by the Society	1,946.94
Miscellaneous Refunds	4,761.50
Old Outstanding Checks Cancelled	5.00
<hr/>	
TOTAL CASH RECEIVED FROM	
REGULAR OPERATIONS	\$339,364.63
COUNTY DUES COLLECTED	12,226.00
AMERICAN MEDICAL ASSOCIATION—	
REGULAR DUES COLLECTED	168,795.00
MEDICAL EDUCATION POLITICAL	
ACTION COMMITTEE	7,375.00
AMERICAN MEDICAL ASSOCIATION—	
DUES PLACED IN ESCROW	735.00
RECEIPTS FOR LOCAL	
ADVERTISING, ETC. BY	
AMERICAN MEDICAL ASSOCIATION	15,325.33
RECEIPTS FROM 1965 CONVENTION BANQUET	4,050.00
RECEIPTS FOR COMMITTEE	
ON MENTAL HEALTH	5,595.44
RECEIPTS FROM 1966 CONVENTION BANQUET	585.00
<hr/>	
TOTAL RECEIPTS	\$554,051.40
CASH BALANCES — JANUARY 1, 1965:	
First Citizens Bank & Trust Co.,	
Raleigh, N. C.	\$ 9,576.28
Cash on Hand	50.00
	9,626.28
TOTAL TO ACCOUNT FOR	\$563,677.68

DISBURSEMENTS

DISBURSEMENTS FOR CURRENT OPERATIONS:

Expenditures—Executive Budget	\$103,515.48
Less: Capital Expenditures—	
Office Equipment	2,109.38
	\$101,406.10
Expenditures—Journal Budget	\$ 62,972.53
Less: Capital Expenditures—	
Office Equipment	31.52
	62,941.01
Expenditures—Intra-Functional	
Activity Budget	28,438.12
Expenditures—Extra-Functional	
Activities Budget	6,266.08
Expenditures—Public	
Relations Budget	\$11,534.73
Less: Capital Expenditures—	
Office Equipment	100.57
	11,434.16
Expenditures—Annual Sessions (111th)	
Convention Budget	23,988.44
Expenditures—	
Miscellaneous Budget	\$ 38,574.85
Less: Capital Expenditures—	
Option on Real Estate	5,000.00
	33,574.85
Refunds of Dues Over Collected	
and Miscellaneous Refunds	4,458.00

SUPPLEMENT TO THE NORTH CAROLINA MEDICAL JOURNAL

Refunds of AMA Dues in Escrow	90.00
Prepaid Supplies	1,179.00
Accrued Pay Roll Taxes—12-31-64	1,251.87
Items Paid by the Society— Billed to Others	1,507.11
Total	\$276,534.74
Less: Deductions from Wages— Unpaid at 12-31-65:	
Pay Roll Taxes	1,485.91
TOTAL DISBURSEMENTS— CURRENT OPERATIONS	\$275,048.83
PAYMENTS TO AMERICAN MEDICAL ASSOCIATION—REGULAR DUES COLLECTED	139,545.00
EXPENDITURES FOR CAPITOL ASSETS	7,241.47
TOTAL DISBURSEMENTS	\$421,835.30
CASH BALANCES—DECEMBER 31, 1965:	
First Citizens Bank & Trust Co., Raleigh, N. C.	\$141,792.38
Cash on Hand	50.00
TOTAL ACCOUNTED FOR	\$563,677.68

CASH ON HAND AND IN BANK
December 31, 1965FIRST-CITIZENS BANK AND TRUST
COMPANY, RALEIGH, N. C.:

Balance Per Bank Statement	\$147,412.16
Less: Outstanding Checks:	
Number 13542 \$ 5.40	
14096 45.00	
14154 8.50	
14174 15.00	
14244 40.17	
14248 283.75	
14254 199.61	
14266 288.99	
14293 4,130.00	
14297 400.00	
14300 20.00	
14301 20.00	
14302 20.00	
14303 20.00	
14304 20.00	
14305 20.00	
14307 83.36	5,619.78
BALANCE PER BOOKS	\$141,792.38
PETTY CASH FUND	50.00
TOTAL CASH—TO EXHIBIT "A"	\$141,842.38

SCHEDULE 2

SCHEDULE OF CAPITAL ASSETS
December 31, 1965OFFICE FURNITURE AND FIXTURES:
EXECUTIVE OFFICE:

Wooden File Case—Letter Size	\$ 21.66
Typewriter Desk	25.00
Steel Office Safe	150.00
Steel File Case—Letter Size	20.00
Four Steel Card Files	20.00
Office Chair	35.20
One Desk	62.55
Steel Filing Cabinet	24.50
Office Desk	47.95
Letter File—Two Drawer	29.46
Steel Filing Cabinet	71.75
Office Chairs	40.00
Office Desk	87.29
Office Equipment—Miscellaneous	1,149.39
One Telephone Table—Wooden	15.45
Two Pairs 12" x 38" C. S. Vents and Brackets	8.77
One Desk Lamp	10.26
Two Master Model Audiographs and Attachments	725.67
One Map of Greater Carolinas	37.50
Two Double Files 3" x 5"	11.86
Three Pendaflex Frames (Installed)	5.57
Two Gray Steel Cabinets	103.00
Three Transfer Files	11.89
One Spec. B. Outfit File	7.25
Two Legal Filing Cabinets	19.90
One Filing Shelf	2.50
Plywood Carrying Case for Audiograph	17.00
Map Framed	3.61

Charter Framed	2.57
Cash Box	2.79
Steel Desk	158.98
Three Desk Trays with Stackers	8.57
Waste Basket	1.40
Large Chair Mat	9.27
Glass Desk Top	11.68
Stenograph and Tripod	100.70
Four Drawer Steel Filing Cabinet	78.03
Four Pendaflex Steel Frames (Installed)	7.42
Postal Scale	6.50
Numbering Machine	14.88
Filing Stool	11.23
Bookcase	63.86
Remington Rand Electric Adding Machine	215.01
Metal Storage Cabinet	78.28
Metal Filing Cabinet	92.76
Two Cabinet Shelves (Installed)	10.30
Metal Cash Box	2.32
Pro Rata Share of Cost of Mimeograph Machine	337.47
Typewriter Table	21.00
Metal Correspondence Separator	6.18
Metal File and Sections	68.55
Two Typewriters— Large Type (Bulletin)	321.23
Kardex File and Parts	1,842.36
Catalogue Case	20.00
Metal File and Frames	93.07
Secretarial Foot Control	25.75
Three Transfer Files	16.23
Junior Pendaflex File	22.87
Book Case Section	16.25
Swivel Chair and Arm Chair	74.48
Audiograph Converter	28.84
Pendaflex File	5.88
Wood Desk and Two Files	281.43
Der Jur Camera with Flash Attachment and Case	100.44
Audiograph Machine—Used	300.00
Flight Bag	38.31
Three Box Files	9.42
Portable Lectern	29.93
Metal File	114.33
Checkwriter — Paymaster	101.48
Desk and Chair	268.45
Supply Cabinet Shelves	25.35
Pro Rata Share of Cost of Imperial Safe ED "60" (Kardex)	290.00
Air Conditioning Equipment— Office	1,621.00
Five-Drawer Letter File and Frames	122.78
Five Transfer Files	20.35
Two Five-Drawer Filing Cabinets	245.56
American Medical Dictionary	25.00
Two Plate Glass Tops for Desks	20.34
Desk, Swivel Chair and Desk Set	253.87
Pro Rata Share of Cost— Vartypewriter — Used	50.00
Pro Rata Share of Cost — A. B. Dick Offset Duplicator	1,602.27
Ten Pronto Files	46.87
Two Four-Drawer Durable File Cabinets	61.70
One Kardex File Safe and Base	593.28
Pro Rata Portion of Postage Mailing Machine	427.85
Pro Rata Portion of Robotypewriter	360.50
Pro Rata Portion of Perforator	121.03
Pro Rata Portion of One Table	18.47
Pro Rata Portion of Postal Scale	12.48
Stenorette Machine #215391	156.06
Stenorette Machine #219890	156.06
Two Transcribing Kits for Stenorettes	60.08
Telephone Adapter and Switch Box	17.66
Two Gray Legal Desk Trays	14.63
Book Case Section #813 Walnut	29.26
Gray Table #1808	49.59
Three Transcribing Kits for Stenorettes	89.75
Four Stetho Clips for Stenorettes	12.00
Documentor Electric Typewriter	372.55
Remington Electric Typewriter #E-2289256	360.21
Pro Rata Portion of Used Addressograph Machine #312185 with Work Table	75.00

Pro Rata Portion of Hand Truck	3.60
Pro Rata Portion of Two Gingher Valets — #7-6-U	26.59
Pro Rata Portion of Remington Electric Typewriter #2129420	153.83
Three Letter Size File Cabinets	103.72
One—TU-24 Stak Tube Roll File	40.00
Pro Rata Portion of One #11919 Paper Cutter	10.70
One—15 ft. x 16 ft. Rug and Mat	144.82
Pro Rata Portion of Five Tables	27.78
One—122H Steel Cart with 3 Shelves	35.76
One Brief Case	53.51
Six Four-Drawer Letter Size Files	199.31
One Documentor	
Electric Typewriter	372.55
One Modern Tub Chair	31.82
Two Bookcases	66.64
One Electric Projection Pointer	77.15
Two Side Arm Chairs, Walnut, Maroon Upholstery	77.62
Two Side Chairs, Walnut, Maroon Upholstery	55.62
One Desk and Chair	44.81
One Conference Table—Walnut	149.81
One Executive Swivel Chair, Walnut, Maroon Upholstery ..	104.37
One Endura Telephone Timer ..	13.11
One Walnut Credenza	125.30
Carpet	63.95
Two Glass Desk Tops	22.45
One Book Case (Used)	15.45
Pro Rata Portion of One Toledo Postage Scale (Used)	77.25
One 3-Section Book Case	137.61
Pro Rata Portion of One Divisumma 24 Calculator	100.00
Mirror—Secretary's Office	1.01
Portable Electric Baseboard Heater	17.82
Lamp for Conference Room	15.43
Drapes and Rods for Conference Room	114.75
Walnut Dictionary Stand	67.07
Costumer	12.98
Four Side Chairs	73.05
Stenorette Portable Dictating Machine and Case #35077	228.11
Pro Rata Portion of One Premier Ream Cutter	130.00
Checkwriter — #XL4-076960	45.05
Pro Rata Portion of One Flex-O- Build Desk End File	38.15
Pro Rata Portion of #1900 Addressograph	200.00
#502 Sort-A-Tray	9.95
Pro Rata Portion of Walnut Step Table	9.25
Pro Rata Portion of White Table Lamp	4.10
Pro Rata Portion of Black Settee	31.08
Pro Rata Portion of Postal Scale Rate Chart	16.13
Carrying Case for Adding Machine	18.49
Electric Fan	19.45
#412 File Unit	15.72
Pro Rata Portion of Verifax Copier	159.38
6-Tier File	8.72
Pro Rata Portion of 4-Drawer Letter File	130.91
Pro Rata Portion of #7795 Virco Desk	16.43
Pro Rata Portion of #4841 Thomas Collator	93.00
File Cabinet, 4-Drawer No. 24A	41.95
Remington Typewriter No. 3064244	388.90
Remington Typewriter No. 3521299	388.90
One Hand Truck	13.59
Steel Shelving	123.60
Walnut Pamphlet Rack	7.00
Plastic Letter Tray	2.17
Two Combination Desk Top Files	19.26
Stenograph Machine No. 645223 (Used)	100.00
One No. 5F Cosco Stenographic Chair	30.85
One No. 1260 Desk—Plastic Top	177.52
One Steno Chair	30.85
One Scriptor 13" Elite Electric Typewriter	311.85
Remington Rand Cabinet Kardex	585.84
4 No. 8B51 5-Drawer Files	401.78
Electric Pencil Sharpener	34.98
60 x 34 Desk	149.25
Feeder Unit for Addressograph	936.53
One KIK Step Stool	13.95
TOTAL EXECUTIVE OFFICE	\$ 22,677.96

PUBLIC RELATIONS OFFICE:	
Four Aluminum Desk Trays with Supports	\$ 9.00
Steel Costumer	14.20
Cash Box	1.50
Supply Cabinet	37.00
Two Waste Baskets	7.00
Metal Executive Desk	112.60
Executive Chair	48.80
Two Side Arm Chairs	60.40
Metal Secretary Desk	136.40
Secretary Chair	30.20
Storage Cabinet	37.00
Two Chair Mats	12.90
Ring Top Card File	1.60
Stapler	4.95
Punch	3.15
Metal Letter File with Lock ..	61.60
Storage Cabinet	37.00
Royal Typewriter	133.31
Two Electric Fans	63.29
Four-Drawer Metal File	69.49
Two-Drawer Metal File with Lock and Base	18.36
Supply Cabinet	75.00
Two Desk Trays and Stacks	4.64
Metal Storage Cabinet	57.29
Pro Rata Share of Cost of Mimeograph Machine	508.53
Pendaflex Frames (Installed)	4.64
Folder Machine and A. B. Dick Stand	397.88
Used Elliott Addressograph	123.83
Two Telephone List Finders	6.06
Pendaflex Frame (Installed)	4.50
Used Projector - Nedco	153.43
Model DLS Screen	32.45
Record Player	101.25
Microphone and Stand	19.40
Projector with Case - Slide	94.47
Lectern Mike	56.85
Display Equipment - Flip Chart ..	31.74
One Camera and Flash	88.98
Film Holders and Adapters	19.00
Metal File	95.79
Pro Rata Share of Cost - Varityper - Used	50.00
Pro Rata Share of Cost - A. B. Dick Offset Duplicator	1,602.26
Pro Rata Portion of Postage Mailing Machine	427.85
Pro Rata Portion of Robotyper	360.50
Pro Rata Portion of Perforator	121.02
Pro Rata Portion of One Table ..	17.58
Pro Rata Portion of Postal Scale ..	12.47
Stenorette Machine #205617	205.06
Pro Rata Portion of Used Addressograph Machine #312185 with Work Table	75.00
Pro Rata Portion of Hand Truck ..	3.13
Pro Rata Portion of Two Gingher Valets - #7-6-U	8.83
Pro Rata Portion of One #11919 Paper Cutter	10.70
Pro Rata Portion of Five Tables ..	27.78
Two 4-Drawer Files Complete with Hanger Frames	194.47
Pro Rata Portion of One Toledo Postage Scale (Used) ..	77.25
One Underwood Scriptor Electric Typewriter - #21-8721980	337.64
Pro Rata Portion of One Divisumma 24 Calculator	327.79
Crestline DeLuxe Projector	79.26
Pro Rata Portion of One Premier Ream Cutter	129.47
Pro Rata Share of One Flex-O-Build Desk End File ...	13.00
Scriptor Electric Typewriter S#8654172	300.00
Pro Rata Portion of #1900 Addressograph	200.00
Pro Rata Portion of Walnut Step Table	9.24
Pro Rata Portion of White Table Lamp	4.09
Pro Rata Portion of Black Settee ..	30.67
Pro Rata Portion of Postal Scale Rate Chart	16.13
Pro Rata Portion of Verifax Copier	159.38
Pro Rata Portion of 4-Drawer Letter File	42.75
Pro Rata Portion of #7795 Virco Desk	15.00
Pro Rata Portion of #4841 Thomas Collator	60.99
One Carri-Voice With Micro- phone No. 44118 and One Revere Model T-300 Tape Recorder No. 3001312	480.00
Two 8B51 Gray File Cabinets	236.66
One 8B51 Gray File Cabinet	100.57
TOTAL PUBLIC RELATIONS OFFICE	\$ 8,512.02

JOURNAL BUSINESS MANAGER'S OFFICE:	
Steel File and Frame	\$ 88.27
Pro Rata Share of Cost of Imperial Safe ED "60" (Kardex)	170.77
Book - "Successful Sales Promotion"	5.65
Pro Rata Portion of Remington Electric Typewriter #2129420	153.83
Pro Rata Portion of Divisumma 24 Calculator	200.00
Pro Rata Portion of #1900 Addressograph	100.00
Stenorette Combination Unit	105.00
One Section No. 811 Hale Bookcase	31.52
Pro Rata Portion of Verifax Copier	106.24
TOTAL JOURNAL BUSINESS MANAGER'S OFFICE	961.28
RURAL HEALTH AND MEDICAL CARE COMMITTEE:	
Masco Tape Recorder	\$ 159.18
One Desk	185.40
One Steel File and Trays	121.29
One Soundscrubber	150.00
Pro Rata Portion of Two Gingher Valets - #7-6-U	8.83
TOTAL RURAL HEALTH AND MEDICAL CARE COMMITTEE	624.70
ANNUAL SESSIONS CONVENTION:	
Portable Lectern	\$ 29.67
Stenorette Machine #219618	205.06
Stenorette Machine #214740	196.75
Stenorette Machine #216837	196.75
TOTAL ANNUAL SESSIONS CONVENTION	\$ 628.23
INTRA-FUNCTIONAL ACTIVITIES:	
Gray Secretary's Desk	\$ 224.35
Gray Secretary's Chair	36.77
TOTAL INTRA-FUNCTIONAL ACTIVITIES	261.12
TOTAL OFFICE FURNITURE AND FIXTURES	\$ 33,665.31
REAL ESTATE:	
Land - Durham-Raleigh Highway - (Schedule - 3)	26,104.55
Option to Purchase Real Estate (N. Wilmington & E. North Street) Expires May 20, 1966	5,000.00
12 Months Ended December 31, 1965	
OTHER ASSETS:	
Capital Stock - State Medical Journal Advertising Bureau, Inc.	200.00
TOTAL CAPITAL ASSETS - TO EXHIBIT "A"	\$64,969.86

SCHEDULE 3 SCHEDULE OF BUILDING SITE COSTS 12 Months Ended

Options	\$ 450.00
Land Purchase - Durham-Raleigh Highway	24,650.00
Legal Service	126.75
Survey and Map of Property	477.80
Architect Service	400.00
TOTAL - TO SCHEDULE - 2	\$26,104.55

REPORT OF THE ASSISTANT EXECUTIVE DIRECTOR

William N. Hilliard

Throughout the period of this report my best efforts have been expended toward whatever goals were charted by the principal officers of the Medical Society. It is my sincere hope that the efforts have been beneficial to the best interest of the Society and the physicians of North Carolina.

Mr. James T. Barnes, in the proper overall coordination and direction of staff activities, has as always been most gracious in his advice and guidance which is particularly helpful and most assuredly appreciated.

My sincere thanks also are due the Chairman of the Public Relations Commission, Dr. David G. Welton, under whose Commission a number of

projects have been undertaken with the individual committees assigned to his Commission. It has been an extreme pleasure to carry out the staffing duties in connection with the Committees of his Commission.

An expression of appreciation is also appropriate for the Chairman of the Committee on Public Relations, Dr. Philip Naumoff, under whose direction several major projects of the Society are carried out. He is always willing to take time for advice and counsel in assisting staff effort.

The Conference of County Medical Society Officers and Committeemen was held on Friday evening January 28 and Saturday, January 29, 1966 at The Carolina Hotel in Pinehurst, sponsored, as in previous years, by the Committee on Public Relations. The Friday evening session of this Conference has developed primarily as a workshop session for Presidents and Secretaries of County Medical Societies. Considerable time and effort was spent on this project, particularly during the fall and winter months, in an effort to make it a worthwhile meeting and one well attended. Due to inclement weather the attendance was not quite as high as had been anticipated, but in spite of that factor the attendance was almost as good as in prior years. A total of 142 persons attended the conference, with 82 of these being physician members. This attendance, despite problems of highway conditions, would seem to indicate that the Conference of County Medical Society Officers and Committeemen continues to be a valuable effort of benefit to the County Medical Society officials in attendance.

One of the special features of the Officers Conference was a presentation by Dr. Joseph A. Sabatier, president-elect of the Louisiana Medical Society, on the topic of problems related to Chiropractic. His talk was accompanied by a number of meaningful audio-visual slides. A tape recording of his presentation along with a set of these slides are available from the Headquarters Office for use by County Medical Societies desiring a program presentation on this topic.

The details of the committee on Public Relations Cooperation with the State High School Science Fair program have been worked out whereby a representative of the Biological Science Division of the State High School Science Fair is invited to display his or her exhibit at the Annual Meeting of the State Medical Society. Criteria for selection of the exhibitor is based on the relationship of the exhibit of medicine.

The Public Relations Bulletin has been edited on a basis of nine issues a year, published monthly except for the months of May, July and August. We strive to make the Bulletin as brief and newsworthy as space will permit in its limited size, as a means for expeditiously reaching the membership. Enclosing material in the mailing with the Bulletin continues to be a popular device for various committees of the State Society and other

organizations desiring to reach the Society membership with messages and information of importance.

A Medical Society State Fair Exhibit was sponsored again during the week of October 11-16, 1965, by the Public Relations Committee, featuring two exhibits from the American Medical Association entitled "We See" and the "Emergency Medical Identification Symbol." The exhibits along with the educational literature distributed at the Fair Booth provided an excellent opportunity for dissemination of health information to some segments of the general public not routinely reached through other avenues of communication. The Fair Exhibit also offered an opportunity for patrons to have their blood type and Rh group determined and receive a pocket size identification card indicating this information. The blood typing service was offered in cooperation with the N. C. Association of Medical Technologists and the Wake County Auxiliary also graciously furnished assistance for the distribution of the educational literature and registration of patrons of the blood typing service.

In cooperation with Hospital Saving Association of Chapel Hill, an AMA pamphlet on the topic of the Emergency Medical Identification Symbol has been reproduced and distributed throughout North Carolina on request along with a pocketbook identification card appropriate for enumerating special medical information concerning medical problems or allergies which should be available on a person in emergency situations. Approximately 100,000 of these pamphlets and cards have been printed by the Hospital Saving Association and distributed to physicians' offices and to hospitals on request following the announcement of their availability in the Public Relations Bulletin.

The Annual Committee Conclave was held September 22-25, 1965. This period involved an intensive period of Committee meetings participated in with staff assignment to work, for the most part, with those Committees assigned to the Public Relations Commission.

The "Information Booklet for Physicians" developed approximately two years ago has been reprinted in a Second Edition, with minor updating corrections and additions. The booklet, along with an Orientation Kit of Information Materials for New Members, is available to County Medical Societies particularly for presentation to new members as they join the Society. The kits are distributed to new members by the Headquarters Office as their membership in the State Society is processed except in cases where the County Society has already delivered the materials to the new members.

A "Reference List of Medical Spokesmen" comprising the County Medical Society Presidents, Secretaries, and Chairmen of the Committee on Public Relations was developed, printed and distributed to the newspapers throughout the state as a continu-

ing effort in behalf of promoting mutual understanding between the medical profession and representatives of the information media.

Gift subscriptions to the AMA magazine TODAY'S HEALTH are being renewed for members of the N. C. General Assembly, Governor, Council of State and Supreme and Superior Court Judges, as a project of the Committee on Public Relations. One subscription for each College Library was added to the list in 1965 and will be continued as a means of making reference health information from an authentic source available to college students.

The 1966 Chamber of Commerce of the United States "Aircade" meeting held in Raleigh on March 9 was attended and it is considered that the time was well spent as background education concerning the major congressional issues facing the nation today. Also attended was the Chamber of Commerce Association Conference on Leadership held in Atlanta, Ga., on March 28, 1966.

Preparation and coordination of publicity efforts in connection with the Annual Session of the State Society have been continued during the year, as well as publicity and promotion of various other Society activities or meetings when they were appropriately of interest to the general public.

We have worked with several different committees of the Society on various projects. The Committee on Insurance Industry continues to meet quarterly with industry representatives comprising the State Committee of the Health Insurance Council and the joint undertaking between the two groups known as the Claim Review Service (C.R.S.) These meetings have been attended and reported on in a staff capacity.

The Committee on Child Health and Poliomyelitis spent time in consideration of recommendations concerning a policy statement about measles vaccine. The Committee on Hospital and Professional Relations along with the Utilization Committee have considered the implications and problems related to utilization review mechanisms required by implementation of P. L. 89-97. The Committee Liaison to N. C. Pharmacy Association is continuing its efforts to work out a Code of Cooperation between Medicine and Pharmacy for the State.

The two day Annual American Medical Association Institute was attended in Chicago, Ill., August 19-20, 1965. Other conferences and meetings attended include: National Council on Medical Television, Ann Arbor, Michigan, May 17-19, 1965; AMA Annual Session, New York, June 19-23, 1965; Special Meeting of the AMA House of Delegates, October 1-3, 1965; AMA Clinical Session, Philadelphia, Pa., Nov. 27-December 1, 1965; and AMA Mental Health Conference, Chicago, March 18-19, 1966.

The Headquarters Office continues as a distribution point for literature, films and program materials, and the office stands ready to assist County Medical Societies wherever possible. To render

such assistance effectively, however, we must first know about your needs. Many aids in the form of literature, films, etc., are available to you on request. The distribution of such health education items as a first aid chart for placing inside of a medicine chest door continues to be a popular item for distribution to the public. Other literature is available for distribution encouraging regular physical examinations.

In conclusion, we emphasize that every effort will be continued to carry out the work of the society as efficiently as possible toward whatever goals may be set by the appropriate officials of the Society.

As an indication of detailed effort statistical reference is made to the following tabulations with regard to the public relations mailings:

April 1, 1965 to April 1, 1966	
Mail received	2,502
Mail dispatched	9,741
News releases mailed	7,200
Films	21
Educational Pamphlets	2,110
First Aid CCharts	1,843
Public Relations Bulletins	33,725
Exhibits	4
Telephone calls (estimated) Local	1,115
Long Distance	250
Respectfully submitted,	
William N. Hilliard	
Assistant Executive Director	

REPORT OF THE ASSISTANT TO EXECUTIVE DIRECTOR

With the direction of Mr. Barnes and the assistance of the entire Staff of the Medical Society, I have become integrated into the many and varied activities of the Society. These past six months have been stimulating and enriching to me in the area of my job. I have found the atmosphere of the association to be of appreciation and at times demanding.

Within this six month period I have attended the Fall Conclave, Executive Council Meeting, Rural Health Conference, Conference of County Medical Society Officers, the N. C. Conference on Implementation of Medicare, and the National Conference on Medical Assistance held in Chicago. My traveling has taken me over 2,000 miles in the State. This milage was taken in reference to request from AMA concerning County Society activities and in reference also to physician placement. Concerning physician placement, time was taken to survey the coastal area around Surf City to determine what is offered to interest a doctor in locating there. Any free time available has been voluntarily given to perform certain MEDPAC activities.

At this time I desire to become better informed

about the business of the Society and to be able to perform my responsibilities in an efficient manner. Also, as time and experience have accumulated, I feel that it would be in order for me to take on committee responsibilities, to extend my usefulness to the Society, and to equip myself with the necessities to be a knowledgeable employee of the Society.

Bryant D. Paris, Jr.
Assistant to Executive Director

REPORT OF THE EDUCATION CONSULTANT

With this Annual Report to the House of Delegates of the One Hundred Twelfth Annual Session of the Medical Society of the State of North Carolina, the Education Consultant reports the third year of service to this professional organization and hereto takes this opportunity to express appreciation for this tenure. It is a privilege to be associated with and serve an organization which is in the main-stream of national, state and community life to make it a better place to live.

The State Rural Health Conference was revitalized this year on October 9, 1965 at the Memorial Auditorium in Raleigh, N. C., through the cooperative effort of the Medical Society Committee on Rural Health and its Advisory Committee, an interesting and informative program was planned and executed through the Medical Society Headquarters Office. At a subsequent meeting of the Committee on Rural Health the decision was made to hold another such conference in the fall of 1966.

In preparation for the 20th National Conference in Rural Health, March 10, and 11, 1967 in Charlotte, N. C., sponsored by the American Medical Association, the Education Consultant attended the 19th National Rural Health Conference at Colorado Springs, Colorado, March 18 and 19, 1966. The Colorado meeting was well attended and it is with great anticipation that North Carolina will welcome this National meeting here in hopes that a big turn out will also be present for the Charlotte meeting.

Both of these Conferences on Rural Health in North Carolina will do much to create an atmosphere of awareness of both understanding and action for better health. Some of the topics certainly to be discussed will include professional health personnel shortages, tetanus immunization, annual physical examinations, measles, vaccine, dental health, and many others.

The State Headquarters Office has served as a clearinghouse for the Committee on Mental Health Project to encourage county medical society programs on mental health topics in the four categories of mental health education, mental retardation and children's services, alcoholism, and medicine and religion. A full speakers bureau on these topics is maintained for suggestions to county societies requesting programs. Each county medical

society program chairman was contacted by one of the physicians participating in this project and through this means some forty county programs were arranged. Honorariums for the speakers are supplied by the project.

This is the year the Mental Health Services for Children Report, a Joint Report of Committees from the N. C. Mental Health Association and the Medical Society of the State of North Carolina, received its final approval and was published with over 3,500 copies distributed to lay and professional people throughout the state. Requests for this publication continue to come into the office from individuals and groups in the State.

The Subcommittee on Alcoholism at its January 18, 1966 meeting developed a Statement of Policy on Alcoholism for the Medical Society of the State of North Carolina. This document is being reviewed and hopefully will be adopted by the Medical Society in the near future.

The Subcommittee on Medicine and Religion met several times in this year and an active program developed. A speaker on medicine and religion was sponsored at the 1965 Officer's Conference in Pinehurst. The AMA Exhibit on Medicine and Religion is in the exhibit hall of this Annual Meeting. A number of county medical society programs on medicine and religion were held this year. Plans are underway to hold a Symposium in Medicine and Religion in April, 1967 in cooperation with the UNC Medical School at Chapel Hill. Physicians and ministers in this five state area will be invited to attend this meeting in Chapel Hill.

The Education Consultant serves as recording secretary to these Committees as well as additional Medical Society Committees. Every effort is made to see that the suggestions and decisions at these meetings are developed and carried out under the direction of the Chairman and the Executive Director and through the Executive Council of this organization.

Other Medical Society Committees served in this manner include, Committee on Anesthesia Study, Committee of Physicians on Nursing, Committee on Cancer, Committee on Chronic Illness and Aging, Committee on Maternal Health, Committee on Occupational Health, Committee Advisory to the Department of Public Welfare, Committee on School Health, Committee on Venereal Disease, and the Joint Committee for the Health Care of the Chronically Ill and Aging.

The meetings and activities of these Committees which the Education Consultant has assisted with are too numerous and extensive to enumerate to you in this report; however, these can be noted in the reports of their chairmen today. Let me assure you, when indicated, the items discussed by these Committees are communicated to the membership promptly.

In connection with these Committee activities liaison and representation is maintained at state

and national meetings. Meetings attended this year are the N. C. Committee on Nursing and Patient Care, N. C. Conference of Social Service, N. C. Nutrition Council, N. C. Rural Safety Council, and the N. C. Mental Health Council. There have been many meetings with the N. C. State Board of Health and the N. C. Department of Public Welfare regarding the implementation of Medicare and Title 19.

Liaison has continued with the rural groups and organizations through the Agriculture Extension Office at N. C. State University in Raleigh, as well as through the Grange, N. C. Farm Bureau, and the N. C. Community and Area Development Association.

Both the Annual and Mid-Year American Medical Association meetings were attended and the National Conference on the Medical Aspects of Sports. Two meetings associated with Chronic Illness Committee activities, the Conference on Home Care, Ann Arbor, Michigan in December, 1965 and the Annual Meeting of the National Council on Aging in March, 1966 were attended.

With this report, I hope you are given some indication of the activities these offices have attempted to provide this year.

Kay K. Zeigler, Education Consultant

REPORT OF THE PRESIDENT OF THE AUXILIARY TO MEDICAL SOCIETY

At the beginning of the year 1965-66, it was the aim of the Auxiliary to the Medical Society of the State of North Carolina to let the helping hands of the doctor's wife reflect and enrich his dedicated service. As we look back over the year we hope this has been done. Each county auxiliary, and there are 57, has endeavored to be of service to its Medical Society, has tried to become an integral part of its community, has worked to promote health education, and made an effort to present the best image possible to the community of medicine, the doctor, and his ever needed service.

The State theme for the year was "Keys to Becoming a Successful Doctor's Wife." There are four keys we need to become successful doctor's wives. These are:

- K for Knowledge
- E for Energy
- Y for Yielding
- S for Service.

The Key K for Knowledge includes education and information on all medical subjects. I have urged all our members to become better informed women, acquainting themselves with medical problems in their communities, learning more about Health Careers, Mental Health, Rural Health, Safety, and Medical Legislation—both on a state and national level.

The next key is for Energy, and here we urged each doctor's wife to keep physically fit and use

her energy in the right direction, for home, family, and community—in that order.

The Y stands for Yielding—in this instance, we are to yield Right of Way to the doctor and his profession.

The last key S for Service explains itself, and I hope that this report will be proof of our service.

Our membership at present is over 2,500, and we hope to show a steady growth. With over 3,500 doctors in North Carolina, we still have a great deal of work to do in order to interest all wives.

The projects of the Auxiliary are many and varied, indeed there is something that each person ought to be interested in. Many of the County Auxiliaries raised money for the AMA-ERF. This was done through bake sales, antique shows, white elephant sales, benefit bridges, etc. Special emphasis was placed on Health Careers. We cooperated with the "Health Careers for North Carolina" in helping to defray expenses in publishing the new Scholarship Manual. County auxiliaries on a local level have had Health Careers Days in the high schools, sponsored Health Careers Clubs, and have set-up a Health Careers Counseling Service for information on Para-medical vocations.

We continue to support our Student Loan Fund with contributions. Nearly \$1,000 was given to this fund. Loans of \$500 each have been made to seven applicants, making a total of \$3,500 that has been used to make possible a medical education for some deserving students.

The four Sanatoria Beds that we support have been used during the whole year. These are located in Wilson, McCain Sanatorium, Black Mountain, and Gravelly in Chapel Hill. They are maintained by a \$10,000 endowment fund for each, and the use of the bed by a patient, preferably from a doctor's family, is paid for from these Sanatoria Bed Funds. Gifts, magazines, and toiletries are sent to the bed patients by the auxiliary members each year.

The Mental Health Research Endowment Fund, which has a \$10,000 goal, is used at the University of North Carolina at Chapel Hill for research in Mental Health. The fund now stands at almost \$7,500. It is hoped that the total will be reached in 1967, and we can start on another worthwhile project.

Emphasis was also placed on International Health Activities, and tons of medicine and equipment were collected for foreign aid progress, for the ship HOPE, and for doctors to use in distress areas. Rural Health and Rural Safety were stressed, and several members, plus the state president, attended the Rural Health Meeting in Raleigh. The Governor's Traffic Safety Symposium was well attended by Auxiliary members. During the year special emphasis was placed on safety in regard to electrocution—noting the danger in wet hands and feet to electrical wires, electric shocks, etc.

We are especially fortunate that we have good

communication lines, both on a national and state level. This year the national magazine, "M. D.'s Wife," has reached each auxiliary member; the brochure, "Direct Line," has been sent to all state officers and chairmen and county presidents from the national office in Chicago. Both these publications have proved most interesting and useful. On a state level each member receives "The Auxiliary News" four times a year, and many local auxiliaries have had their own news sheet—one in particular is called "Med-itation."

Our activities have taken several of us outside the state for travel. A full quota of delegates (12) attended the Convention of the Woman's Auxiliary to AMA held in New York City. There were several alternate delegates and guests present from North Carolina also. In October the president and president-elect, through courtesy of AMA, attended the Fall Conference in Chicago and the Southern Regional Conference in Atlanta. The meeting in Atlanta was also attended by our State Health Careers, Community Service, Mental Health, Membership, Legislation, and AMA-ERF Chairmen. Our own Fall Workshop was held in Greensboro at UNC-G, with an attendance of 125. The Mid-Winter Committee Projects Conference, held in Pinehurst, was attended by a few brave souls. The rest were snowed out.

Without the support of the Medical Society, the work of the Auxiliary would be impossible. We cannot thank you enough for this financial aid, and just knowing you are backing us up in our endeavor makes all the work worthwhile. After all, every woman needs a good man to fall back on. We cannot thank you enough, and now you are helping us even more. A part-time secretary has been our dream for years. As of March first, this dream became a reality. We do appreciate this wonderful help.

Again may I express my appreciation to Mr. Barnes and Mr. Hilliard, and the staff at the Executive office in Raleigh, for the wonderful cooperation and consideration, and also to the officers and members of the State Medical Society. I hope we are worthy of your support and interest. Call on us. We wish to prove our reason for being, for, after all, every wife wants to be needed.

Thank you,

Leila George Sikes (Mrs. C. Henry)
President, Auxiliary to the Medical
Society of the State of N. C.

FIRST MEDICAL DISTRICT

The First District of the North Carolina Medical Society has no eventful problems or solutions to report.

We are happy to welcome Dr. Dan Burroughs to Hatteras where a new medical clinic will soon be open to give service to the people of the Outer Banks for the first time.

Our Post-graduate Extension Series was presented in January and February at Ahoskie, Edenton and Elizabeth City. This was well attended considering snow and dangerous traveling conditions.

As Councilor I attended all meetings of the North Carolina Medical Society Executive Council. I feel that harmony and understanding among the members is being improved.

The Tri-State Medical Society, as well as the Seaboard Medical Association will again meet at Nagshead in June, 1966.

The First District is in the capable hand of Dr. J. B. Ruffin of Ahoskie.

W. H. Romm, M.D., Councilor

SECOND MEDICAL DISTRICT

The 2nd Medical District has had a good year. The entire district is organized into component societies and there has been a high level of professional conduct and medical practice. One instance of violation of medical ethics has occurred and is currently under consideration. All component county societies meet with good regularity and function as units of the State Medical Society. There are spots of inertia and somewhat slow attention to organization duties, but these are at a minimum.

The 2nd District held its annual meeting as host of the Carteret County Medical Society on October 11, 1965, at the Rex Restaurant in Morehead City, N. C. The meeting was presided over by Dr. John Way of Beaufort, N. C., and a very fine dinner was enjoyed. A talk by Dr. Charles Flowers of the School of Medicine of the University of North Carolina followed. Already plans are about completed for the next meeting of the 2nd District which will be held by the Martin-Beaufort-Hyde-Tyrell-Washington counties group, better known as the Pamlico-Albemarle Medical Society, to be held April 7, at the Washington Country Club. On the agenda at that meeting is a discussion of whether the same type annual district meetings will be continued.

As Councilor I have attended all state meetings and visited considerably in the 2nd District.

My personal suggestions for the district would be to make the District Meetings more appealing in order to spur better attendance and interest.

Lynwood E. Williams, M.D., Councilor

THIRD MEDICAL DISTRICT

The Third Medical District had a normal year for 1965. The Councilor was not called on to make any special investigations. Complete harmony prevailed. The medical programs and social functions were outstanding.

As Councilor I have attended all Executive Council meetings.

Dewey H. Bridger, M. D., Councilor

REPORT OF 4TH DISTRICT COUNCILOR

The recently revitalized Fourth District Society continues to thrive. Semi-Annual meetings of the Society are well attended and excellent programs have been presented.

On February 10, 1966 the Wilson Memorial Hospital, in cooperation with the Wilson County Medical Society and other professional groups, presented its first annual Symposium, in the topic of "STROKES". This Symposium, attracted a registration of 254 physicians, not counting Wilson County Physicians. Several out-of-state physicians participated in this program.

Several new hospital building projects within the district (at Goldsboro, Nashville, and Wilson) are in various stages of development.

Intra-professional relationships in the District have remained harmonious.

E. T. Beddingfield, M.D., Councilor

FIFTH MEDICAL DISTRICT

There have been no notable administrative problems in the Fifth District during the last year. Many of the component county societies have elected the optional central billing offered by the State Office. I would like to point out that except for local county society dues, it would appear desirable for all county societies in the district to elect central billing for district, state and national dues. This would prevent delays in crediting individually paid dues until the entire county membership is paid up as occurs in some county societies.

The Fifth District held its annual meeting in October 1965 at the Mid Pines County Club in Southern Pines with excellent attendance and show of interest. In addition to well prepared clinical presentations the annual business meeting was conducted and Dr. Charles Speas Phillips of Southern Pines installed as President. Dr. John Stanley Vetter of Rockingham was voted as President-Elect for the coming year, and Dr. Duwayne Douglas Gadd of the Pinehurst Surgical clinic was re-elected as Secretary-Treasurer.

Members of the Ladies Auxiliary were in attendance and contributed no small part to the success of the program.

Harry H. Summerlin, M. D., Councilor

SIXTH MEDICAL DISTRICT

Since the last annual report from the Sixth Medical District of the Medical Society of the State of North Carolina, those members from this district have, in addition to their busy practices, been occupying themselves with preparation for implementation of the many new Federal and State laws effecting the practice of medicine. This work has been carried out as individual component societies and the elimination of the Sixth District Medical meetings has not appeared to effect the participation of its doctors as members of the North Carolina State Medical Association or the American

Medical Association.

The Councilor has attended all meetings of the Executive Council including two special meetings called for the purpose of considering the new medical legislation.

Along with representatives of the headquarters offices, the Councilor attended and represented the Medical Society at a Health Careers Work-Shop at the Jack Tar Hotel in Durham on December 6, 1965.

Practice goes on harmoniously in the Sixth District, and no incidents involving mal-ethics were brought to the attention of the Councilor.

As far as can be determined, this has been a successful and productive year for the Sixth District Medical Society.

John Glasson, M.D., Councilor

SEVENTH MEDICAL DISTRICT

Councilor has been in contact with the officers of all component societies on several occasions during this year. There was no formal district meeting but the problems which were assigned to this councilor by the headquarters office have been worked out satisfactorily . . . and no major difficulty has arisen.

Several representatives from county societies in this district attended a meeting of the Charlotte Public Relations Society in November 1965.

The county societies in this district were well represented at the officers and committeemen's conference in Pinehurst on January 29, 1966.

David Goe Welton, M.D., Councilor

EIGHTH MEDICAL DISTRICT

The Councilor has not been made aware, this year, of any problems in the District regarding the members. No formal meeting has been held, and with consent of the Executive Council, a pro-rata refund of monies left in the District Treasury is being paid to the component societies who have contributed in the past. There have been the expected doubts and reservations about implementation of the new Social Security Laws and their effect on the physician, but apparently the feeling within the District is one of cooperation, but some skepticism remains about the mechanism of assuring a reasonable and customary fee for the physician.

There has been some confusion about central billing and statements to the effect that MEDPAC-AMPAC voluntary contributions should be more separately stated.

Louis Shaffner, M. D., Councilor

NINTH MEDICAL DISTRICT

The annual Ninth District Meeting was held Sunday, August 29, 1965, in Salisbury. The President, Dr. Tom Thurston had an excellent program with Representative Broyhill, Dr. Ernest Craige and Dr. David Sabiston being the featured speakers.

Next year's host will be Catawba County. Dr. Thomas E. Fitz was elected President and Dr. Neel Bronnenberg was elected Secretary and Treasurer.

The physicians of this District have expressed to the Council considerable concern regarding the relationship of the hospitals, Blue Cross and Blue Shield to the Medical profession, particular in view of the increasing role of the Federal Government in medical care. Many feel that the time has come for a full re-evaluation of our relationship with Blue Shield.

T. Lynch Murphy, M.D., Councilor

TENTH MEDICAL DISTRICT

No major problems have been presented to the Society from our area this year. The Tenth District Medical Society has ceased to be a functioning unit.

No attempt is being made at this time to re-activate the meetings.

J. S. Raper, M. D., Councilor

ADVISORY AND STUDY COMMISSION

The annual report of the Advisory and Study Commission cannot be considered as complete, since there is a flurry of continuing activity, particularly among the committees whose affairs have been affected by Medicare, prevailing-fee concepts, fee schedules, and Relative Value concepts. Most of the committees met at the conclave at Pinehurst and most of the committees have had subsequent meetings. The committee Advisory to The Auxiliary, and Archives of Medical Society History learned that the Auxiliary membership had reached a new high, at 2,516 members. Many fine auxiliary programs are now in progress. The Archives and Medical Society History projects are making steady progress under the seasoned leadership of Dr. Roscoe McMillan. The committee on American Medical Education and Research Foundation has continued its efforts and has considered ways and means of enlargement of the scope of its projects. The committee on Blue Shield has been quite busy with activities concerning the administration of Parts A and B of Medicare, along with its other duties, including adjudication of claims. Recent attention has been focused on anticipation of working more closely with the internists in their relationships with The Blue Plans. The committee on Constitution and By-Laws recommend minor changes in wording, prior to reprinting of the Constitution next year. A consideration of possible limited tenure for various committee, board, and council positions was discussed, with a view of possibly rotating out older participants to make room for the new. The committee to work with the Industrial Commission has met and is scheduled to meet again, for adjudication of certain cases, and the continued efforts in behalf of making certain low fees more realistic and in line with the relative value of the service, as compared with certain other compensation remun-

erations. The committee on Medical Care of Dependents of Members of Armed Forces has recently been reviewing pertinent preliminary data concerning renegotiation for the schedule of allowances for Dependents of the members of the Armed Forces Program, since renegotiation is to be made in the new contract of October 1, 1966. The committee, Advisory to Student A.M.A. Chapters reported great strides of progress last year, and Dr. Peete has arranged for an increased participation at the next Annual Session, including a panel session and a dinner meeting. The committee on Marriage Counselling has met several times under the sparkling chairmanship of Dr. Rachel Davis, who has spearheaded the presentation of interesting symposia relative to marriage and its many interesting and challenging aspects.

The component committees have cooperated at all times with their commissioners. Their more intricate and elaborate reports of their labors will appear in this compilation.

W. Howard Wilson, M.D., Chairman

REPORT OF THE ANNUAL CONVENTION COMMISSION

The Annual Convention Commission for 1965-1966 consisted of six committees. As in previous years, the Committee on Audio-Visual Scientific Post-Graduate Instruction, headed by Dr. John C. Grier, Jr., arranged the audio-visual presentations for the Asheville meeting. The Committee on Scientific Exhibits, headed by Dr. Robert E. Miller, made arrangements for this phase of the program. The Committee on Scientific Works under the chairmanship of Dr. David Sabiston did an outstanding job in arranging the programs for the General Sessions, to be held May 2-4, 1966 in Asheville.

The Committee on Scientific Awards under the chairmanship of Dr. Lester Crowell, Jr. and the Committee on Credentials to the House of Delegates with Dr. Charles B. Wilkerson, Jr., has functioned and will continue to function as in previous years.

The final committee under this commission is The Committee on Arrangements. The Secretary of the Medical Society, Dr. Charles W. Styron, served as Chairman with Dr. John Hoskins as co-chairman. There were also two consultants appropriate for the Asheville meeting plus ex officio consultants who serve as chairmen of the standing committees stated above. Your Commissioner of the Annual Convention Commission feels that this is a considerable improvement in efforts to coordinate the planning of the Annual Convention and recommends that it be continued.

Paul F. Maness, M.D., Chairman

PROFESSIONAL SERVICE COMMISSION REPORT

The Professional Service Commissioner is happy to report that all committee's under this commission

have been functioning satisfactorily during the past year. All committees met at the Committee Conclave in Pinehurst in the latter part of September.

The Committee on Professional Insurance has reported a sixty-five percent participation among the doctors in the Professional Liability Program and that no rate structure change had been instituted. Mr. Ralph Golden was made agent of record for the Society.

The Necrology Committee has made plans to honor members of the Medical Society who have deceased during the past year.

The Committee on Disaster Medical Care has reviewed the capability of the State of North Carolina to cope with health care during various types of disaster including nuclear disaster. The Medical Self-Help Program has been reviewed and the committee has urged its institution into the high school program throughout the State. The committee strongly recommends disaster rehearsal in every community throughout the State.

The Committee on Retirement Savings Plan has executed a master agreement establishing the North Carolina Medical Retirement Savings Plan and Trust and this has been executed by the President of the State Medical Society. Plans have been made in presenting this program to every Medical Society in the State.

The Committee on Eye Care & Eye Bank after reviewing a questionnaire sent to the Ophthalmologists of the State has evaluated the existing policies of eye physicians in North Carolina. This committee has submitted a resolution maintaining the right of every physician to dispense eye glasses or contact lens to those patients who desire to be fitted by him.

A very active Committee on Nursing has met on several occasions. They have also had joint meetings with other agencies throughout the State interested in the problems of the nursing shortage. The physician is urged to give careful attention to the report of this committee and should be mindful of the urgency of this situation as it affects the Medical Care of the physicians patients.

In summary, all committees of the Professional Service Commission have most diligently applied themselves to the problems confronting them and after careful deliberation and consideration, have made outstanding contributions to bettering professional service.

Mark M. Lindsey, M.D., Chairman
Professional Service Commission

PUBLIC RELATIONS COMMISSION

Since each committee chairman will submit a detailed report, the nature of my report will be that of a summary attempting to point out certain significant and important activities.

Hospital and Professional Relations & Committee on Liaison to N. C. Hospital Assoc., James S. Raper, M.D., Chairman.

This committee has continued to function effectively in the area of specific problems arising in various parts of the state.

The Council authorized members of this committee who are members of the N. C. Radiological Society to proceed with negotiations with the N. C. Hospital Association in order to permit radiologists working full time in hospitals to bill all patients individually for their professional services of interpretation.

Legislation: E. T. Beddingfield, Jr., M.D., Chairman.

This is a large and complex subject about which Doctor Beddingfield has compiled a detailed and comprehensive report.

Medical Legal: Julius A. Howell, M. D., Chairman.

This committee re-emphasized the importance of dissemination of the "Medical-Legal Code of North Carolina" developed by our society in conjunction with the North Carolina Bar Association. It has worked on specific problems such as handling of emergency room patients, use of registered nurses in regard to emergency closed chest cardiopulmonary resuscitation; and a joint meeting of the medical-legal committees of the medical society and the bar association was held.

Public Relations: Philip Naumoff, M.D., Chairman.

A full and comprehensive report has been submitted by Doctor Naumoff. The annual officer's conference, which was arranged largely under his leadership, included such outstanding speakers as Leo Brown from the A.M.A. Staff, the regional direction of H.E.W. from Atlanta, and Paul McCleave head of the department of medicine and religion at the AMA, made the program very worthwhile.

Rural Health: Edward L. Boyette, M.D., Chairman.

This committee is working hard to assist in the plans for the AMA's council on rural health's national meeting to be held in Charlotte March 1967. They will welcome suggestions from any member of the society to help make this an outstanding event. This committee sponsored a Rural Health Conference October 9, 1965, in Raleigh with outstanding speakers on medical care for the aged, environmental health center, and community health activities.

Insurance Industry: Jack Mohr, M.D. Chairman.

This committee has carried on its functions of meeting at least every three months and part of the meeting is the N. C. Insurance Claims Review service in conjunction with representatives from the commercial insurance carriers. They have a very full agenda each time and carry on a very vital function. Our president-elect, Frank W. Jones, who has served as chairman of this committee for some years, stepped down at the time of the last meeting with the acting co-chairman taking his

place. Doctor Jones has prepared a comprehensive and detailed review of the year's activities which will be found below.

Pharmacy, Liaison to N. C. Association: John T. Dees, M.D., Chairman.

This committee has perfected and drawn up a proposed "physicians-pharmacists code of understanding" between the Medical Society and the N. C. Pharmaceutical Association. It was approved by our executive council and is awaiting approval of the Pharmaceutical Assn. The committee's chief effort during the year has been that of working with the State Department of Public Welfare developing the program of the Kerr Mills Act. They have also been active in disseminating a booklet on drug abuse, a manual for law enforcement officers printed by Smith, Kline and French.

This chairman also reported that "an advisory committee of plan of assistance for the development and improvement of pharmacy service in N. C. hospitals" by the N. C. Hospital Education and Research Foundation with purpose of recruiting, orienting and training registered pharmacists for full or part time service in hospitals throughout our state.

Advisory to Department of Motor Vehicles: Simmons I. Patrick, M.D., Chairman.

This committee has continued to operate very smoothly and efficiently in cooperation with the state motor vehicles department. The system of 30 anonymous physician consultants who do special medical examinations upon request from the motor vehicle department is a valuable public service which is largely unpublicized and so far the physicians who do this work are not compensated for it financially.

It was stated that the Institute of Government was planning to conduct a program of training for driver license examiners.

Between May 1, 1964 and August 1, 1965, over 18,000 cases were referred to the medical consultants for review and a statistical analysis of these is being carried out by the School of Public Health at UNC-CH.

Association of Professions: John R. Kernodle, M.D., Chairman.

The second annual meeting of this association was held March 24, 1965, in Raleigh, with John R. Kernodle, M.D. presiding. New officers of the association for the current year are Dr. Earl L. Knox, President, (DVM).

At the present time this association includes individual memberships for architects, pharmacists, physicians, professional engineers, and veterinarians.

Utilization Committee: H. Fleming Fuller, M.D., Chairman.

This is a new committee charged with the responsibility of gathering all available information on hospital utilization committees and developing guidelines after several special meetings, this was accomplished and the guidelines are in the process

of being sent to each chief of staff of each hospital in the state and to each county society president. This was a new and difficult undertaking but the many persons who were invited to cooperate did so and it is believed that a very useful guidelines has been developed.

This concludes my report.

David Goe Welton, M.D., Chairman

PUBLIC SERVICE COMMISSION

The Public Service Commission reports that each of the committees of this Commission have been active in promoting the health and welfare of the people of North Carolina.

Your Medical Society is proud of the good work done by these committees and you are referred to the reports of the individual chairmen of the committees:

Anesthesia Study
Cancer
Child Health & Poliomyelitis
Chronic Illness
Maternal Health
Mental Health Medicine and Religion
Occupational Health
Physical Rehabilitation
Advisory to Department of Public Welfare
School Health
Venereal Disease

Thomas G. Thurston, M. D., Chairman

COMMITTEE ADVISORY TO THE AUXILIARY

I. This committee, through its chairman, has been in frequent contact with the president and the officers of the Auxiliary throughout the year. They have consulted us on matters of policy and new programs.

As usual, the Auxiliary has had many worthwhile projects. I can only mention briefly a few of the most important ones. They are as follows:

1. MEDPAC
2. Community Service
3. Disaster Preparedness
4. Health Careers
5. International Health Activities
6. Mental Health
7. Rural Health
8. Special Projects: Four Tuberculosis Sanatorium Beds, Student Loan Fund, and Mental Health Research Endowment Fund

I was much impressed with the theme of the Auxiliary President, Mrs. C. Henry Sikes (Leila George) of Greensboro, throughout the year: "Keys to Becoming a Successful Doctor's Wife." The four keys are:

1. K — Knowledge
2. E — Energy
3. Y — Yielding
4. S — Service

The workshop and fall board meeting in Greensboro was very instructive and, I am sure, was a

great help for the Auxiliary throughout the year.

Archives and Medical Society History

II. This program is making steady progress. I am now getting to the point where I am considering editing the report. I am hoping we may be able to hold the history to two volumes. After all subcommittee reports are in, I will have a definite report on the costs, etc. This will be rendered sometime during the year.

Roscoe D. McMillan, M.D., Chairman

COMMITTEE ON AMERICAN MEDICAL EDUCATION AND RESEARCH FOUNDATION (AMAERF)

The following is the annual report of the American Medical Education & Research Foundation. This committee met on September 24, 1965, at the Carolina Hotel, Pinehurst, N. C. Those present were Harry B. Underwood, M.D., chairman, William L. Fleming, M.D., W. Howard Wilson, M.D.

I. The request to the committee on Public Relations for a place on the January program was again thought to be necessary to gain more personal contact for our committee. This request was subsequently approved. Subsequently, the chairman of the committee did appear on the banquet program January 28, and presented the program of the AMA-ERF committee to the delegates. The following other suggestions were made for the coming year:

- A. An AMA-ERF Exhibit at the Annual Meeting
- B. Securing a film from the AMA on AMA-ERF to show at the Audio-Visual section at the Annual Meeting
- C. Having an interim committee meeting inviting representatives from each of the Medical Schools including their lay alumni representatives, preferably in Pinehurst and in conjunction with the January PR conference.

The Committee went on record as favoring distribution of the AMA folder "A Handbook for Making Bequests to Medical Research" to the State Banking Association, Bar Association and Certified Public Accountants.

The Committee discussed the merits of enlarging the Committee membership, since the results of Committee activities depend greatly on personal contact and there is need for representation in more areas of the state.

The total donated for North Carolina during 1965 was between five and six thousand dollars which was less than the 1964 contribution of \$9,597. The committee hopes that with more personal attention being taken between officers of the county societies that the contributions for 1966 will again increase.

Harry B. Underwood, M.D., Chairman

COMMITTEE ON ANESTHESIA STUDY

The Committee on Anesthesia Study met on Thursday, September 23, 1965 at The Carolina in Pinehurst, North Carolina. Present were Ben C. Ogle, M.D., John C. Doerr, M.D., John R. Hoskins, III, M.D., Thomas G. Thurston, M.D., Kay K. Zeigler, Deanna Massey, and Luther C. Hollandsworth, M.D., Chairman.

Slides were presented summarizing this committee's findings of the past three and one-half years, during which time 675 questionnaires were sent out. This detailed report was concerned with the resuscitative efforts employed in 102 deaths considered to be preventable from the standpoint of anesthesia. This report appeared in the North Carolina Medical Journal, January, 1966.

The Committee also discussed the need of revitalizing this group with new members, interested in the problems with which this study is concerned.

Luther C. Hollandsworth, M.D., Chairman

COMMITTEE ON ARRANGEMENTS

The Committee on Arrangements met with Charles W. Styron, Chairman presiding at 8 p.m. on September 23, 1965 at the Carolina Hotel, Pinehurst, N. C. Plans were reviewed for the Asheville meeting in May 1966.

Space assignments for technical and scientific exhibits were examined and proved to be adequate. Meeting rooms for the House of Delegates, General Session, Memorial Services, luncheons, etc. have been assigned.

The banquet and ball will be held in the auditorium and the banquet will be catered by the George Vanderbilt Hotel. This catering service has been used previously and has proved satisfactory.

Arrangements have been made with the Buncombe County Medical Society to accommodate special guests through the host committee. The Medical Society and Auxiliary also have arranged for entertainment and accommodations through host committees.

The Committee discussed at length arrangements for future meetings. The Carolina at Pinehurst was recommended for 1967. A definite date of May 14-17, 1967 is being held. It is possible that this date may be advanced to an earlier date in May. The Carolina has offered its facilities for the Annual Meetings of 1968, 1969, and 1970 with corresponding May dates.

The Headquarters Office is to explore the possibility of using blister housing for exhibit space. Tents may be used also for the 1967 meeting.

There is to be an addition to the Carolina Hotel consisting of a ballroom with full basement. This addition will be utilized for exhibit space in future meetings. The ballroom will be ready by 1967 but it is unlikely that the basement will be ready by that time.

The meeting adjourned at 10:00 p.m.

Charles W. Styron, M.D., Chairman

COMMITTEE ON

ASSOCIATION OF PROFESSIONS

The North Carolina Association of Professions has enjoyed a good year with increasing interest and participation of its Board of Directors and its individual membership. The number of state professional organizations holding membership has remained the same as last year, however, there is re-newed interest on the part of the N. C. Dental Society to join the Association at its May, 1966 annual meeting.

The Officers for the year have been: President, Earl L. Knox, DVM of Raleigh; Vice-Presidents: William W. Dodge III, A.I.A., first vice-president and John S. Rhodes, M.D. as second vice-president; Secretary, W. J. Smith, Ex. Secretary of the North Carolina Pharmaceutical Association; and Treasurer, Robert G. Bourne, P.E. All officers have been active in carrying out their assigned duties during the year.

The 1965 Annual Meeting held March 24, 1965 in Raleigh was an important step forward for the Association. The General Assembly was in session and members invited to the luncheon session as guests of the Association. Governor Dan K. Moore was the luncheon speaker and publicly recognized the Association of Professions as the "voice" of the professional leadership of the state and encouraged its growth and promotion.

In addition to the Governor, other outstanding authorities addressed the annual meeting. They were: Dr. Ralph Fadum, P.E. Dean of Engineering, N. C. State University at Raleigh; Dr. Austin Smith, President, Pharmaceutical Manufacturers Association, Washington, D.C.; Leslie N. Boney, A.I.A., president of the North Carolina Chapter, American Institute of Architects; Dr. Don Spangler, DVM, president-elect, American Veterinary Medical Association; and Aubrey D. Gates, Director of Field Services, American Medical Association, Chicago, Illinois. The Theme of the Second Annual Meeting was "Inter-Relationships Between the Professions".

The Board of Directors, comprised of six appointed members from each of the state member groups, held four meetings during 1965. One at the March annual meeting in Raleigh; in June at Sedgewild Inn, Greensboro; September in Pinehurst, joint meeting with the Medical Society's annual Committee Conclave; and in December, at the Research Triangle. All meetings were well attended and had invited guests speakers.

In October, the Association assisted with the promotion of the state-wide Road Bond Issue by mailing some 7,000 leaflets to professional members asking them to encourage citizen vote in support of the 3 million dollar program. In the same mailing, the membership campaign for 1966 was initiated.

During the year, a quarterly News Bulletin was started, with the first issue distributed in October, 1965 and the second issue in January, 1966. The

name of the bulletin is "INTRA-COM" — Communications of the Professions. Favorable comments have been received from many members of this direct contact with individual members and it is used as a public relations piece of information about the Association.

The Legislative Committee was busy during the 1965 session of the General Assembly and in the first issue of the News Bulletin, the chairman briefed legislative programs enacted that applied to any member professional group. This summary was most helpful and can still be used as a quick reference for members.

Close contact is maintained with Congressional members in Washington and with State government leaders by the Association, and the response from these leaders has been most complimentary and appreciated.

The Education Committee has launched a program of recruitment in the professional fields through "Professional Clinics" scheduled for three Community Colleges in the spring of 1966. The purpose of these "clinics" is to interest beginning college students in further training for selected professional services. A second purpose is to give guidance counselors and college staff specific information as to requirements for professional training, the length of time required, and any information on scholarship that will be helpful to them in working with students. The three "clinics" are scheduled for 1. Central Piedmont College in Charlotte on March 14th; 2. Southern Community College in Whiteville on March 17th; and 3. Sandhills Community College on April 19th. Each clinic will have one representative serve on a panel discussing educational requirements and training and a second member assisting with group discussions as to practice opportunities and the need for additional practitioners in North Carolina. This effort on the part of the Education Committee had already stimulated a great deal of interest among our Junior and Community Colleges.

The third Annual Meeting of the Association is scheduled to be held on March 9th at the Robert E. Lee Hotel in Winston-Salem, N. C. Again, outstanding speakers have accepted invitations to appear on the program. The Theme for the 1966 meeting is "Professional Education" and the afternoon panel will follow the same pattern of educational requirements and training opportunities, and the need for professionals, as planned for the Community College "clinics". Panel members will be: Henry L. Kamphoefner, F.A.I.A., Dean of the School of Design at the N. C. State University at Raleigh; Robert L. Tuttle, M.D., Associate Dean from the Bowman Gray School of Medicine, Winston-Salem; Walter J. Seeley, P.E., Dean Emeritus of the College of Engineering at Duke University; Edward G. Batte, DVM, Head of the Animal Disease Section from the School of Agriculture and Life Sciences at the N. C. State University at Raleigh and G. P.

Hager, Dean of the University of North Carolina School of Pharmacy at Chapel Hill. Guidance counselors from all colleges in the Piedmont section have been invited to attend.

The "key-note" speaker will be Mr. John S. Forsythe, Chief Counsel for the Senate Committee on Labor and Public Welfare, Washington, D. C. Mr. Forsythe will discuss current federal legislation pertaining to professional training.

The Board of Directors will meet during the morning for Committee Reports; Election of Officers; and other Association Business.

The focus of attention for 1966 will be on education and increased membership. The Association is now operating on the calendar year with \$5.00 individual membership dues for the year. Presently, renewals of 1965 membership and new memberships totals 260. Of this number, we have 60 physicians; 14 architects; 57 professional engineers; 28 veterinarians; and 101 pharmacists. We had a total of 362 members in 1965. If the dentists join in May, we will reach our 500 goal easily.

The Association of Professions is still a new organization, however, its past activities and contacts have been most meaningful and effective so that it has gained the recognition it set out to accomplish since its beginning, four years ago.

On behalf of the Association of Professions, we wish to thank our physician Board members and Consultants for their continued interest and participation in this important state organization.

John R. Kernodle, M.D., Chairman
Medical Society Committee

COMMITTEE ON SCIENTIFIC AUDIO-VISUAL POSTGRADUATE INSTRUCTION

A meeting of the Committee on Scientific Audio-Visual Postgraduate Instruction was held on Friday, September 24, 1965, The Carolina, Pinehurst, North Carolina, for the purpose of developing the program for the Annual Meeting in Asheville, North Carolina, April 30-May 4, 1966.

Plans were made to again present the audio-visual program on Monday and Tuesday—morning and afternoon sessions.

The Postgraduate and Audio-Visual Program was distributed in loose leaf form with the March Issue of the PR Bulletin and is also printed in the Program of the One Hundred Twelfth Annual Session of the Medical Society of the State of North Carolina.

John C. Grier, Jr., M.D., Chairman

COMMITTEE ON AWARDS

Awards Committee choices from presentations at the May, 1965 session of the State Society:

1. Moore County Award to Dr. Archibald Lipe Barringer; Mount Pleasant for "Chronic Urethritis in the Female." Section on General Practice, May 4, 1965, Charlotte.
2. Gaston County Award to Dr. Carl Norris

Patterson, Durham for "Physiologic Septoplasty and Rhinoplasty." Section on Ophthalmology and Otolaryngology, May 4, 1965. Charlotte.

3. Wake County Award: None chosen.

L. A. Crowell, Jr., M.D., Chairman

COMMITTEE ON BLUE SHIELD

The past year was one of much activity for the Blue Shield Committee and dominated by events beyond our control.

The prior chairman, Dr. W. Z. Bradford, found it necessary to ask to be relieved of responsibility of the chairmanship due to illness. This experienced leadership was a great loss to the Committee and we wish to take this opportunity of recording our appreciation and respects to Dr. Bradford for his fine service during his tenure of office. It is a pleasure to note that Dr. Bradford has made a fine recovery and regretfully deferred to the judgment of his physician that his extra curricular activities be limited for the present.

The second event, one of a cataclysmic nature as concerns prepaid medical care, was passage of Medicare, Public Law 89-97. This legislation passed in a more comprehensive form than had been imagined and engaged the Committee in a great deal of activity. The Committee, in line with AMA policy, believed that physicians should exercise a maximum role in so far as possible in shaping policy and administrative practice of the Medicare Program in the best interest of their patients and hospitals. The Committee believed that the maximum physician role could be achieved best through Blue Cross and Blue Shield, whose organizations have physician members on their Boards of Trustees and professional matters are under the guidance of the Blue Shield Committee. Therefore, a recommendation was made to the Executive Council that the Medical Society endorse the joint appointment of the Blue Shield Plans in North Carolina as the administrative agent of Title XVIII, Part B of Medicare. This recommendation was adopted by the Executive Council. On behalf of the State Medical Society, the President, Dr. Paschal wrote to Mr. John W. Gardner, Secretary of Health, Education, and Welfare, requesting that the Blue Shield Plans be named the intermediary carrier for Part B. There was some prior assurance that the Secretary would give serious consideration to an informed choice by organized medicine. Although the Blue Shield Plans of the country were appointed as carrier of Part B in an area comprising 59% of the population, the appointment for the State of North Carolina was awarded to a commercial company. No acknowledgement from HEW to the Medical Society has been received as of this writing nor has HEW or Society Security made any explanation. Protests of the Medical Society and of the Chairman of the Blue Shield Committee have been unacknowledged as of this writing. In retrospect, it appears that Blue Shield, as the choice of the carrier, was un-

doubtedly the official position of the State Medical Society and the desire of the majority of its members. However, it is acknowledged that a minority of physicians representing one or two Committees and specialty groups may have favored a commercial carrier and made this known in Washington, thus weakening the force of the State Society's request.

In view of the Society recommendation of Blue Shield as Medicare administrator, the Committee and Plan officials did much work in preparation for a comprehensive statewide survey of current charging practices. It was anticipated that such a survey could be used to administer Medicare on the basis of usual and customary and reasonable professional charges. This survey and payment method is known as the Blue Shield Prevailing Fee concept. It is anticipated that this survey, on a more limited basis, will gradually be implemented for Blue Shield member accounts; however, in view of Medicare developments, the full scale survey of all services in all areas has been deferred.

The Committee has met at regular intervals and considered many diverse subjects and adjudicated numerous individual cases. Presentations were heard from physician guests relating to particular problems in anesthesia, radiology, and other subjects. The Committee anticipates working closely with doctors practicing internal medicine, seeking to find the cause and eliminate some administrative misunderstandings that have developed.

Your Chairman and the Committee is indeed grateful for the close interest and guidance of President George W. Paschal, M.D. Plan officials have been exceedingly cooperative and responsive to the Committees' interest and wishes. Mr. James T. Barnes, Executive Director of the State Medical Society, and Mr. K. G. Beeston, the Committee Secretary, have been tremendously helpful.

Max P. Rogers, M.D., Chairman

COMMITTEE ON CANCER

The Committee on Cancer held its annual meeting September 24, 1965 in Pinehurst, North Carolina.

A report was read from Dr. James Donnelly, State Board of Health, concerning the expanding cytology program in the State Lab. This service was established for physicians in North Carolina to obtain Pap smears for indigent patients, but gradually many physicians have been sending private patients' Pap smears to the State Lab.

This problem has been discussed by the State Society of Pathologists and they voted to do Pap smears for indigent patients at no charge. The eighty pathologists in the State are willing to cooperate in this manner and Dr. Donald S. Morris, Dr. Arthur Davis, Jr., and Dr. Victor Vickokiko were present representing the pathologists.

Letters have been sent by the State Lab to physicians appealing to them to stop sending private patients' smears and State Board of Health per-

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sonnel have visited private physicians concerning this matter.

A recommendation was passed by the Cancer Committee which was sent to the Executive Committee that there should be a gradual phasing out of the cytology program in the State Lab beginning on a county level and to be extended over a period of years; that all positive smears which require a repeat smear requested by the State Lab will immediately be sent to a private pathologist in the local area; that the State Board of Health write another letter to every doctor sending smears to the State Lab stating that only indigent patients' smears should be sent to the Lab.

Dr. D. E. Ward, Jr., President of the Board of Trustees of the North Carolina Cancer Institute, Lumberton, N. C., reported that during 1965 the Institute admitted and treated more patients than any previous year. A full time medical director, Dr. James Martin, is doing an excellent job with the patients. Only terminal indigent cancer patients are admitted to the Cancer Institute through arrangements in the local county welfare departments.

It was reported that Governor Dan Moore stated that the Cancer Commission would be a permanent commission due to the increase in cancer death rate in North Carolina.

This Committee would like to express its deep sympathy in the passing of Dr. D. F. Milam, State Board of Health, who was a tireless worker and an inspiration to his fellow physicians in his efforts for the control and treatment of cancer in our State.

One case of cancer quackery was investigated during the year and appropriate measures were instigated to control the situation.

D. E. Ward, Jr., M.D., Chairman

COMMITTEE ON CHILD HEALTH AND POLIOMYELITIS

The committee met in Durham in January and discussed the possibility of implementing a statewide mass measles vaccine program. It was decided after due consideration that this was not a feasible project at this time and that a publicity program regarding the use of the vaccine and importance of the disease directed both towards physicians and the public should be undertaken.

The committee has served in an advisory capacity to the State Board of Health in the implementation of their PKU testing program and in distribution of the measles vaccine to be received under the Federal Immunization Act.

Richard S. Kelly, Jr., M.D., Chairman

COMMITTEE ON CHRONIC ILLNESS, TUBERCULOSIS AND HEART DISEASE

The Committee on Chronic Illness held its first meeting of the year at the Conclave of Committees of the Medical Society of the State of North Carolina at Pinehurst, North Carolina, on September 23, 1965. A considerable portion of this meeting was

devoted to reports and discussion that the impact of PL 89-97, particular title 18, would have on North Carolina.

Representatives of the Nursing Home Association of North Carolina, N. C. Hospital Association, N. C. Department of Public Welfare, N. C. Medical Care Commission, N. C. State Board of Health, and the Blues Agencies discussed with the Committee how this law, when implemented in North Carolina, would affect their agencies, organizations, and individual members in the continued delivery of the high quality patient care which has been characteristic of North Carolina. Although the regulations were not available at this time, Dr. Edgar T. Beddingfield reported what impact it would probably have on the physician.

Due to this discussion at this same meeting the Committee passed a resolution that a Conference on Medicare be held in North Carolina. It was passed on to the Executive Council and approved. Further elaboration on the planning and the meeting will be found in the body of this report.

Other topics for discussion at the meeting were "Functions and Approaches of the Chronic Illness Committee" and "A National Program to Conquer Heart Disease, Cancer and Stroke", an AMA Staff Report. Both of these items are receiving the continued interest and attention of this Committee and will be reported on from time to time.

The Committee continues its representation in state, regional, and national meetings which pertain to its activities and interest. This continued liaison representation and reporting is maintained through the attendance by the Chairman, members of the Committee, the Executive Director, the Assistant Executive Director, and the Education Consultant through their singular or dual representation at such meetings which is reported to the Committee by them.

Meetings attended this year include the Annual Meeting of the National Social Welfare Assembly, New York City; the National Conference on Manpower Training and Older Workers sponsored by the National Council on Aging, Washington, D. C.; 2nd National Voluntary Health Conference, AMA, Chicago; The Conference on Home Care, Ann Arbor, Michigan, and the Regional Conference on Community Health Services, Atlanta, Georgia. Numerous meetings have been held with the N. C. State Board of Health, N. C. Department of Public Welfare, N. C. State Nurses' Association, Nursing Home Association of North Carolina, and other organizations and agencies in the State. Members of the Committee have been invited to speak at lay organizational meetings.

The Committee has continued its support and representation on the Joint Committee for the Health Care of the Chronically Ill and Aging which has met twice—May 12, 1965 at the Sir Walter Hotel and December 19, 1965 at the College Inn, Raleigh, N. C.

State agencies and Health professional groups which are members of this Committee have faithfully attended these meetings and reported on their activities. This has not been an action group, rather a device for continuous liaison and revelation of ongoing activity related to the aged.

At the December 19, 1965 meeting considerable time was spent on reporting from each group of current programs and activities other than Medicare. A report was made on the history of the Joint Committee. It began in 1957 and was formalized in 1959 at which time it broadened its representation. The report pointed out the Joint Committee is advisory in nature, and its decisions are recommendations that can be carried back to the parent organizations. The report also indicated that since the Committee is made up of individual organizations, this helps to clarify needs and document reports which places this information in the picture of total care. The objective of the Joint Committee is to improve the health care of the people. The report observed that the Committee continues to demonstrate the 3 c's—communication, coordination and cooperation.

The Joint Committee regretted to see the retirement of Dr. John R. Kernodle from its Chairmanship which he has so ably and dutifully filled over the past years. Dr. Thomas R. Nichols, past Chairman of the Medical Society Committee on Chronic Illness and Aging assumed the leadership as Chairman of the Joint Committee. Two items have been suggested for the Joint Committee to focus its attention on in the coming year. It will be considering ways of getting people out of long term care homes and back into the community. The matter of developing a report of the activities of each member group which can be kept up to date and placed in a file to be studied from time to time will be looked into.

The Joint Subcommittee on Chronically Ill and Aging composed of the N. C. State Nurses' Association, the Medical Society of the State of North Carolina and the N. C. State Board of Health met in September 1965. This liaison activity on spot problems of inter-relationship has been most helpful in coordinating the activities of these three groups.

The Committee has concentrated most of its efforts this year on the cooperative planning and conducting the Conference on Medicare. Following the approval of such a conference by the Executive Council, the Committee on Chronic Illness sought the support and planning assistance of representative leaders evolved so as to hold a conference involving other organizations and agencies in the state which would be affected by P.L. 89-97.

Three planning meetings were held with these groups. A selected group of these organizations and agencies met on October 25, 1965 at the Sir Walter Hotel in Raleigh, and agreed on major details of such a meeting on the state level to study

"Medicare" and its implications as this would be most helpful. At this meeting those present decided the meeting would be called the N. C. Conference on the Implementation of Medicare and Related Services and would be held Thursday and Friday, January 27 and 28, 1966 at The Carolina Hotel in Pinehurst, N. C. The general objectives of the conference were outlined. It was agreed at this time that a Steering Committee be appointed to plan the details of the conference after which a final planning meeting would be held of all participating groups. The Steering Committee met on November 8, 1965 at the Medical Society Headquarters in Raleigh to discuss the format of the Conference. General sessions were planned with national and regional speakers and workshops would be held following the general sessions.

It was agreed at this meeting, due to the limitation of the meeting facility, that the conference should be invitational with around 245 participants with an assigned specified number of invitations to each organization.

At the December 19, 1965 meeting of the Joint Committee for the Health Care of the Chronically Ill and Aging it was voted to co-sponsor the N. C. Conference on the Implementation of Medicare and Related Services with the Medical Society of the State of North Carolina. Afterwards the final planning session for the conference was held.

The number of invitations to the twenty groups presented at the December 19, 1965 meeting were assigned. The meeting divided into seven groups and considerable time was spent on developing basic questions on the topic of each workshop. To the names of representatives furnished by the participating groups, invitations and minutes of the planning sessions were issued from the Executive Director of the Medical Society's Office, 203 Capital Club Building, Raleigh, N. C.

All groups involved were most cooperative in arranging to have representatives of their groups to be present at the Conference. Due to severe weather the meeting was cancelled for Pinehurst and rescheduled at the Sir Walter Hotel in Raleigh for February 18 and 19, 1966.

Representatives of the Health Education and Welfare Administration both regional and national addressed the Conference in Raleigh. Seven workshops on the topics of Hospitalization, Physician Services, Services Available to Eligible Public Assistance Recipients, Nursing Home Services, Home Care Services, Patient Evaluation and Placement, and Continuity of Care were the highlights of the Conference. Those present felt the objectives which were set down at the beginning of the planning of the Conference were accomplished. Information was imparted, coordinated planning and discussion occurred, and the impact of the law on the pattern of medical care, facilities and personnel was discussed. Much complimentary post-conference evaluation has been cited to the Medical

Society for the effective content and management of the conference.

At the closing session workshop moderators presented summaries and recommendations. The Conference proceedings will be compiled and made available to those who are interested. Pertinent recommendations are being reported to the Executive Council of the Medical Society.

D. A. McLaurin, M.D., Chairman

COMMITTEE ON CONSTITUTION & BY-LAWS

The report of the Committee on Constitution and By-Laws will be given to the House of Delegates on May 1, 1966.

Louis deS. Shaffner, M.D., Chairman

COMMITTEE ON CREDENTIALS OF DELEGATES

The Committee on Credentials of Delegates was present and performed necessary functions in certifying delegates for seating in the House of Delegates meeting on Sunday, May 2, 1965, in the Merchandise Mart, Charlotte, North Carolina. All delegates were checked and certified to the Secretary for declaration of a quorum.

No particular problems arose during the meetings of the House of Delegates in 1965.

Charles B. Wilkerson, Jr., M.D., Chairman

COMMITTEE ON DISASTER MEDICAL CARE

The Committee on Disaster and Medical Care met on September 24, 1965, in the cocktail lounge at The Carolina Hotel in Pinehurst, North Carolina. Doctor William Anlyan, Chairman of the Committee, called the meeting together at 9:00 a.m.

The first item discussed was the capability of North Carolina to supply adequate health care during nuclear disaster or during any type of disaster.

During the discussion, Doctor Paschal gave a summary of the past activity of this Committee. It was pointed out that this Committee had previously been called the Emergency Medical Care Committee. The Committee on Disaster Medical Care has established a liaison with the Civil Defense Service in the State of North Carolina and appears to work with them fairly well, although to a limited degree.

Colonel Dawson pointed out that 96 of the 100 counties in North Carolina have disaster plans on file with the Civil Defense Office. He stated that some of the counties in the State had made considerable progress in Civil Defense preparedness while others have done very little. Apparently, Durham County has done more in this area than any of the others.

Packaged disaster hospitals are stored throughout the State and their locations were indicated upon maps distributed by Colonel Dawson. Initially these hospitals were stored to be used only for disaster so specified by the Federal Government. However, recently the rules concerning the use of these hospitals have been changed so that now they can

be utilized for emergency needs during medical disasters without requiring an act of Congress.

It was pointed out that disaster preparedness, although begun on a state level, had to be worked out on a county, city, and even hospital level in order to be effective. The State is divided into six emergency care areas, and there is a coordinator for each. It was pointed out that all the subdivisions in these areas need to practice preparedness in order to be ready for a disaster.

Colonel Dawson distributed schedules indicating the amount of shelter in the various counties and discussed activities to increase the shelter.

Mr. Hawkins then discussed the packaged disaster hospitals and their distribution. Originally these hospitals were stored in any space available, occasionally without adequate inspections. Some of the materials in these hospitals have become damaged due to the inadequate storage. Recently the Public Health Service has begun giving qualification inspections prior and during the storage and replacing all outdated materials. Although it is the responsibility of the local government to supply safe and adequate space for these hospitals, the Public Health Service is required to inspect the spaces periodically. These packaged hospitals are scattered throughout the State and are not necessarily nearby or adjacent to large medical complexes. The problem of transporting supplies to and from these packaged hospitals was discussed. It was felt that in the future packaged hospitals might be more numerous and might be stored within or adjacent to existing medical complexes.

It was pointed out that it takes 12,000 square feet to store one of these packaged mobile hospital units. Dr. James Davis asked that after these "kits" were exhausted to whom could one turn for supplies. Colonel Dawson replied, "To the Civil Defense Agency from the county who would in turn apply to the area office." He indicated that medical supplies at the wholesale houses, pharmacies, etc., in the State would be "frozen." He indicated that a recent survey to determine how many medical supplies were available revealed that there was enough to last for at least five days.

The Medical Self-Help Program was discussed. This is a program whereby from films and manuals a minimal number of instructors can train large groups of individuals in how to give first aid, how to survive certain medical emergencies, and how to administer to others. It was indicated that North Carolina is one of the few states in the country that has done very little in this type of preparedness. It was pointed out that anyone who has any ability in teaching can be instructed in teaching this course and can give the course. Attempts have been made to get this course offered in the high schools; however, this has been unsatisfactory (because of opposition from the school board) although it was felt by the entire committee that this is certainly the place where the course should be

taught. It was indicated that less than 13,000 people have received this training in North Carolina.

Further discussion on the Medical Self-Help Programs indicated that Boy Scouts, Girl Scouts, and other large groups were to be taught this material. It was felt that not only the high schools but colleges, church societies, and civic groups should encourage and support this training program.

It was recommended that this Committee send a strong endorsement of the Medical Self-Help Program to Doctor Carroll and request his help in getting this course taught in the high schools. It was also suggested that the Parents-Teachers Association might be contacted and list their aid in getting the course offered in the high schools.

Another point discussed was the manpower requirements for disasters and how they could be fulfilled. It was suggested that counties that do not have very many doctors, nurses, etc., should go out and get lists of retired persons, married persons, or other individuals who are no longer active in the medical profession and put them on a temporary standby basis in case of disaster. Dr. Warner Wells stated that this standby basis was similar to what they had instituted at the Memorial Hospital at the University of North Carolina. He also stated that they had a ladder of succession in case of injuries to top personnel so that there would always be a chain of command in their disaster unit.

Doctor Clippinger commented on his experiences as MEND Coordinator at Duke. He stated for the past eight or nine years disaster rehearsals have been run and then proceeded to discuss some of the findings from these rehearsals. One of the most important things learned from the Duke disaster rehearsals is that a primary treatment area, which is large, which can be reached without the use of electrical power (a place on the main floor of the hospital), and which is convenient to supplies, is a must in caring for mass casualties. These conditions have been met at Duke by using the main dining hall which can be rapidly cleared and used as a disaster treating and sorting area. The patients are triaged on entrance to the hospital. They are then taken to various areas within the large dining hall where they may be treated for 24 hours or more with adequate care. The moribund are, of course, to be taken to the morgue. All the others are sorted and taken to appropriate areas within the dining hall.

The shock patients are taken care of the moment they are brought in and fluid started. If people need to go to the operating room, they are sorted either before they enter the large waiting area or maybe directed from the dining area to the operating rooms.

Doctor Clippinger pointed out that problems have occurred each time that have not been considered previously and that the disaster plan does not always go according to plan. However, some things

that have been learned are that (1) the patient does not have to be rushed through the various areas, and (2) there is no substitute for rehearsals except a real disaster. Doctor Clippinger concluded that rehearsals are not only worthwhile but that they are mandatory.

At the end of the meeting it was suggested that letters be written to Doctor Carroll requesting that Medical Self-Help be incorporated into the high school curriculum. Also, it was suggested that a letter be written to Mr. Schiedt about ambulances observing traffic laws, and a letter be written to the County Medical Society Presidents about the Disaster Medical Care film which is available to county societies. The President of the North Carolina Medical Society will attempt to have this film placed on the program of the State Medical Society meeting.

COMMITTEE ON SCIENTIFIC EXHIBITS

The Committee on Scientific Exhibits for 1966 had its first meeting at The Carolina, Pinehurst, N. C., on Friday, September 24, 1965, during the Committee Conclave.

Each member of the Committee was asked to solicit exhibits for display at the 1966 Annual Meeting. Application forms were distributed and exhibits were obtained from the various national meetings throughout the country as a result of applications being furnished exhibitors on the spot at these various meetings.

Letters were written to approximately 100 exhibitors asking that they consider exhibiting at the Annual Meeting of the Medical Society in May 1966 with very good response.

On February 4, 1966, the Committee met in Charlotte to review the applications for exhibit space and at that time thirty exhibits were selected and letters of acceptance were written immediately thereafter. Since that time the Committee has accepted exhibits reaching a total of thirty-eight.

The final action of the Committee will be in working with the headquarters staff, the exhibitors and the display company in setting up the exhibits in the Exhibit Hall of the Asheville City Auditorium, Asheville, North Carolina, on Saturday, April 30, 1966.

Robert E. Miller, M.D., Chairman

COMMITTEE ON EYE CARE AND EYE-BANK

The Eye-Bank Association of America moved its national headquarters to Winston-Salem, N. C. The EBAA and the N. C. Eye-Bank Inc. will share the new building in the Medical Complex on Maplewood Avenue, Winston-Salem, N. C. 27103. Over thirteen hundred eyes have been handled for eye tissue use by the N. C. Eye-Bank Inc.

On May 2, 1965 the House of Delegates of the Medical Society approved the following Relative Value Unit Schedule after ten years of evaluation and discussion by about 185 physicians rendering

eye care in North Carolina, and the Committee on Relative Value Fee Schedules:

#5405	Refraction with cycloplegic	4.0 units
#5400	Refraction without cycloplegic	3.0 units
#5448	Removal of foreign body under slit lamp	3.0 units
#5415	Fitting prosthetics	8.0 units

The Eye Care Committee has cooperated with all the bills of the Legislative Committee of the Medical Society of the State of North Carolina. They have endorsed the following:

1. The "Battered Child" Law.
2. The "Good Samaritan" Law.
3. The Nursing Education Bills.
4. The amended Gun and BB Law.
5. Opposition to the Chiropractor Bills.

After tabulating the votes of eye physicians in North Carolina, the Committee cooperated with the Traffic Advisory Committee of the N. C. Department of Motor Vehicles and recommended the following: that Form DL-78 #2, N. C. Department of Motor Vehicles, Drivers License Medical Report, be amended to read:

- "1. Do you see two? Yes.... No....
2. Are you receiving blind aid? Yes. No....
3. Do you receive double deduction for loss of vision? Yes.... No....

"VISUAL: Visual acuity:

1. Without glasses:

RE 20/..... LE 20/..... BE 20/.....

2. With glasses:

RE 20/..... LE 20/..... BE 20/....."

The information was mailed to all eye physicians about fees for refractions, lenses, etc., about the Teamsters Union Vision Care, 1221 North LaSalle Street, Chicago, Illinois 60610.

It has been inferred that although National Republic Insurance Company handles this, it is not subject to North Carolina insurances because it is a welfare plan.

Information was mailed to all eye physicians in North Carolina about *exclusions* affecting eye care under Public Law 89-97, Title 18 A & B: "Section 1862: where such expenses are for 'eye glasses or EYE EXAMINATIONS for the purpose of prescribing, fitting, or changing eye glasses, hearing aids, etc.'"; and OASI-1965-2-GPO: 1965-0-781-220, page eight: "some items and services are not covered under either plan: e.g. *eye glasses, hearing aids, private duty nurses, and telephone or television in your hospital room*".

The eye physicians were sent three questionnaires during the year to vote about eye care problems to assist the Eye Care Committee in formulating its policies. Ninety-seven per cent of eye physicians in North Carolina who voted that the medical doctor should control the fitting of contact lenses, frames and lenses, and that the eye physician should sell frames, contact lenses and glasses (lenses) if he desired, or recommend one who sells contact lenses,

frames, or glasses lenses. However the patient would have freedom to purchase these where he desires.

L. B. Holt, M. D., Chairman

COMMITTEE ON FINANCE

The finances of the Society are in good shape relative to the 1965 operation of the Society. The Auditor's Report elsewhere in the compilation will substantiate this finding of the Committee on Finance.

On the advice of the Society's Legal Counsel, fully reviewed by the Executive Council, the Committee on Finance is recommending the formation of a non-stock corporation to be known as the "North Carolina Medical Foundation, Incorporated."

It is common information that like and similar organizations may become involved in matters of related sources of income in support of its educational and scientific pursuits due, in measure, to court rulings and opinions held in recent years. This may particularly affect supportive incomes which make the educational and scientific aspects of the Society's Journal and Scientific and Technical exhibits programs possible and effective. The same may ultimately affect the cushioning reserves for the continuous operation of the Society and its future progresses in behalf of the public health and the public good. Though there are no apparent wrongs in the operation and functions at present carried on in the activities of the Society the alternate establishment of the aforementioned North Carolina Medical Foundation, Inc., appears to be a sound undertaking.

This proposal of a foundation is a proper means, provided by law, to undertake to comply with the spirit and letter of the law as may be interpreted by agencies of government at this time; so the Committee on Finance recommends that the Society proceed with the authorization and implementation of such a foundation.

A further matter of interest to this Committee is the progress of action of the Committee on Headquarters Facility relative to optioned property in Raleigh upon which there are prospects of constructing a headquarters building for the Society. The Committee on Finance recommended a fund for the purchase of such an option in 1965 and we anticipate a progress report on this during the Annual Meeting.

The Committee on Finance was not satisfied at returns on the Society's invested surplus in the "mutual fund" which yielded 6.7% for the year 1965 and hope to make some change for improvement in the future.

The Administrative Commission will have no further report to make in this Compilation of Reports.

Wayne J. Benton, M. D., Chairman

COMMITTEE ON GRIEVANCES

Several complaints have been submitted to the Committee on Grievances during the past year most of which have been amicably settled by correspondence. The Committee has held one meeting at which time most of these complaints were amicably settled. There are two matters still under consideration which will probably require another meeting of the Committee before the annual meeting in May.

It has not been found necessary to take any disciplinary action toward any member of the Society in adjudicating these matters and it is felt by the Committee that most of these have arisen from misunderstanding and lack of communications.

Amos Johnson, M. D., Chairman

HEADQUARTERS FACILITIES COMMITTEE

History of the Committee

The Headquarters Facilities Committee first met in 1955 and recommended that the Society acquire a building site on Raleigh-Durham Highway No. 70. A 52-acre tract, at a cost of \$26,104, was purchased in 1956. A brochure with an outline of a building costing \$350,000 was prepared for the Executive Council and House of Delegates at the 1957 meeting. The Executive Council received the Committee report without recommending action. In 1958 the Committee recommended that the Society consider a proposal to locate headquarters facilities in the Research Triangle. This was decided against, in favor of seeking residential property in the city of Raleigh for temporary use, with the ultimate building to be on the Highway No. 70 tract. No such property was found to be available. An inquiry was made into the possibility of building with, or leasing to, other health organizations with negative results. The 1959 Committee recommended building on the Highway No. 70 tract and exploring the construction of a modern, efficiency-type building, rather than the more artful structure. Additional space was obtained in the overcrowded facilities in the Capital Club Building. It was the accepted recommendation of the Administrative Committee Chairman that the Committee on Medical Society Headquarters Facilities be dissolved, since the question of building would be dormant for the time being. Dr. Paschal has reactivated the Committee for consideration of building our own Medical Society Headquarters Facilities.

The latter of these locations seemed so much more desirable that I had an architect, Mr. Charles Davis, of Raleigh, draw up feasibility plans for building on this property which is presented. You will see from the study that the two story building of 10,000 sq. ft. leaves very adequate parking as well as additional space for attractive landscaping. The one block distance from the State House shown on the street map is noteworthy. This property is being held by the owners for sale to the Medical Society until Monday morning, at \$2.50 a sq. ft., or

\$90,000. Adjacent to the property there is a smaller lot, not a corner lot which recently sold for \$4.00 a square foot.

5) Financing a building within walking distance of the legislature with plenty of parking is feasible. The cost of land would be \$90,000; of building a 10,000 sq. ft. building (\$20 sq. ft.,) \$200,000; total: \$290,000. The tract on the Raleigh-Durham Highway has recently been evaluated at \$163,500. The Society has in reserve \$156,045, in Mutual Investors, St. Paul, Minn., which gives it a total of \$319,545.

Considerations of Building Headquarters Facilities

1. The Society should consider adequate space for facilities, offices and meeting rooms furnished in a manner in keeping with the dignity of the profession.

2. Building on the Highway No. 70 tract would be undesirable because it does not have city bus service for Headquarters Facilities employees. The Executive Secretary and his aides need easy distance, preferably walking distance, to the state legislature buildings.

3. The present facilities occupy 3,600 sq. ft. at the Capital Club Building at a rent cost of \$2.26 per sq. ft., per year. The one meeting room is small and will only accomodate a dozen people at most. For many of our committee meetings this one room is inadequate. The absence of parking facilities makes it poorly accessible.

4. Areas Investigated for building:

- 1) 1006,000 sq. ft. Wade Ave., West of Oberlin — \$100,000 at 90c per ft.
- 2) 165 ft. x 230 ft. Oberlin Road — \$75,000 at \$2.00 per ft.
- 3) 44½ ft. x 148 ft. next to Andrew Johnson Hotel, \$90,000.
- 4) Redevelopment Commission property \$1.25/\$1.50 sq. ft.
(Peace-Salisbury St. area, 2½ blocks from option purchased October 1965, at cost of \$5,000 to be applied to purchase price not later than June 1, 1966.
- 5) Glenwood Ave.
- 6) E. North St.—Wilmington St.—\$90,000 at \$2.50 sq. ft. 240 ft. x 150 ft., 36,000 sq. ft.

COMMITTEE ON HOSPITAL AND PROFESSIONAL RELATIONS

During the year, your committee has met, considered problems as they have arisen and has determined appropriate action. It is worthy of note to the Society membership that we have been asked by "hospital based physicians" to take action to aid in the promotion of ethical principles of medical practice of this group. Yet, there is a trend among some members of our society to recommend at a local level the employment by hospitals of physicians for out patient and emergency departments.

We earnestly recommend that the membership continue to be concerned with our proper legal and

ethical relationships with hospitals in the practice of our profession.

J. S. Raper, M.D., Chairman

COMMITTEE TO WORK WITH NORTH CAROLINA INDUSTRIAL COMMISSION

This committee and its sub-committees have met several times during the year. Two formal meetings were held with the full Industrial Commission at the hearing rooms in Raleigh. The work of the committee has been concerned chiefly with two broad areas.

The first area has been that of assisting Dr. John W. Morris, Medical Director, in arbitrating fee disputes within the bounds of the North Carolina law. Because of the fine work of Dr. Morris this has been a relatively minor problem.

The second broad area of concern has been in seeing that our physicians are paid fairly for their services in industrial cases. This committee does not feel that present fees are what they should be. The adoption of a new fee schedule is an extremely difficult and time-consuming problem. It is hoped that the relative value principle will be adopted by the Industrial Commission and that once this is done a new fee schedule with indicated increases will soon be forthcoming. Representatives from the committee are to meet with representatives from the employers' and insurance carriers' groups before the State Society meets in May, 1966.

J. S. Mitchener, Jr., M.D., Chairman

COMMITTEE ON PROFESSIONAL INSURANCE

The committee on Professional Insurance has continued an active, working relationship between its members and the executive administration of the Society and representative insurers of programs of insurance endorsed by the Society. Periodic committee meetings with excellent membership attendance have been held during the past year with representatives from the claims investigation division of the St. Paul Insurance Company, the Professional Liability Plan insurer endorsed by the State Society. A continued review is had and medical advice is rendered to the claims investigators concerning individual physician negligence and malpractice claims that have been initiated against Society members. This procedure enhances for the Society membership the benefits of the endorsed Professional Liability program. In addition, a report was prepared and presented by the St. Paul Insurance agents to the committee at its Conclave Meeting at Pinehurst which reflects the loss-ratio experience of the Professional Liability Program since its inception. The change made in the program in 1964 whereby the premium rates were stepped to reflect vulnerability of classes of physicians to malpractice claims, has had a favorable result on the loss-ratio. This will in all probability be reflected in a decrease in premium rates next year.

In any event, the Committee continues to examine the program to the end that the broadest adequate coverage can be obtained for Society members for the least amount of premium.

With particular reference to the Group Major Medical Hospital Plan, written by the Continental National American Group Company, the Committee has been unofficially advised that a notice of cancellation of the plan with a proposed increase in premium rates and structural policy provision changes will be made by the insurer this year because of an extremely poor loss-ratio since the inception of the program. Should this occur, the Committee will be active in receiving and considering proposals for a Major Hospital Expense Plan to replace the existing program. Here, again, the goal of the Committee will be to seek the broadest coverage for the least amount of premium for the Society membership.

During the past year, the Committee has discussed at length the advisability of a Society endorsed life insurance program that can be submitted for individual selection. The Committee members feel that a Group Life Insurance program would be greatly beneficial to the younger members of the State Society, and would complement the existing endorsed insurance programs. To this end, a Committee resolution was proposed for action by the Executive Council of the State Society requesting permission for the Committee to examine and recommend endorsement of a suitable group life insurance program.

James F. Martin, M. D., Chairman

COMMITTEE ON INSURANCE INDUSTRY

On behalf of the Committee, the chairman reports to you on the activities of the 1965-66 administrative year. This report encompasses the activity of the Liaison Committee and the Medical Section of the North Carolina Insurance Claims Review Service (C.R.S.).

Regular quarterly meetings were held jointly but separately with the North Carolina State Committee of the Health Insurance Council. Since the last formal report, meetings were held on April 7, June 30, September 22, and January 19. A further meeting is scheduled for April 30, 1966. A called meeting at the direction of the Executive Council was held jointly by this Committee and the Blue Shield Committee in connection with a study of prevailing fees in North Carolina, on November 4, 1965.

The Insurance Industry Committee, by a margin of one vote, went along with an amended version of the original Blue Shield Resolution pertaining to the prevailing fee study.

The Committee was successful in securing the approval by Insurance Commissioner Lanier of COMB-1 in North Carolina as an approved form for the physician reporting of health insurance claims. This form is a combination of the individual and group forms and was prepared and approved

on a national level by the A.M.A. and the H.I.C. In this effort, we had the wholehearted support of the N. C. Committee of the Health Insurance Council.

Several geographic area surveys were done by Committee members at the direction of the Committee in the field of "going rates" as such applies to physician charges for selected items. Arising out of this, the Committee recommended that the Society conduct a survey of usual and customary fees and that the results of such would be the sole property of the Society. This proposal was not deemed wise by the Council because of a possible expense item of \$10,000.

The Committee endorsed, at its June 30, 1965, meeting, the stand of the A.M.A. earlier that month which stated, in general, that when government assumed any part of the financial responsibility for the health care of an individual that physicians should be also paid on the basis of usual and customary charges.

The Claim Review Service handled a number of submitted cases for review. The Service repeatedly pointed out that only physicians voted in these decisions and that the charge made to a patient by a physician was no concern of theirs and that their function was only to determine the obligation of the insurer to his insured based upon the insurer's own contractual (policy) language. Only one case was non-industry-submitted, and this case was decided by the Insurance Section in a situation wherein a carrier should pay based upon his policy language. The claim was paid within five days of company notification.

The Committee proposed and submitted to the Executive Council a recommendation that a reputable insurance company be endorsed as also being acceptable to the Society as a carrier for Part B of Title XVIII of PL 89-97. The Council rejected the proposal by a split vote.

Many, many other areas of discussion and action leading to the common good in the area of voluntary insurance were handled, and a reviewer is referred to the recorded minutes of this Committee for details. At the last meeting of the Committee prior to the preparation of this report, the current chairman stepped down and the group selected Dr. Jack Mohr to be acting chairman subject to the approval of President Paschal for the remainder of the administrative year.

Inasmuch as this report is the swan song of this particular chairman as far as this Committee is concerned, he wishes to insert, based upon a personal privilege, into the record a laudatory and heartfelt thanks to those many physicians who have served ably and well on this Committee from time to time since its organization in January 1959. He wishes that space would permit him to list all their names. He would be remiss if he did not also give special thanks to Mr. William N. Hilliard, Assistant Executive Director, assigned by Mr. James T. Barnes, Executive Director, to staff this Committee

for these years.

Frank W. Jones, M. D., Chairman

COMMITTEE ON LEGISLATION

Since submission of the last annual report, the Committee on legislation has been kept extremely busy by continuing developments on both the National and State legislative levels.

A. State Legislation

1. "Good Samaritan Act"—This legislation; although not sponsored by the Society, did involve the Committee upon invitation of the Senator introducing the measure. This bill, which was enacted into law, provided certain immunity to civil action when any citizen (including physicians), acting in good faith, provided emergency road side assistance to accident victims.

2. Sterilization—The statutes relating to Voluntary Sterilization to provide for the legal voluntary sterilization of males (by ligation of the vasa deferentia) outside licensed hospitals. The requirement for hospitalization in a licensed hospital for sterilization of females was not changed. An additional amendment to the voluntary sterilization act of interest to physicians, was enacted. This permits the voluntary sterilization of married females without the consent of their husbands in the event the husband has abandoned the wife for a period of at least six months.

3. Certain budgetary requests of the State Board of Health, State Department of Mental Health, and State Board of Public Welfare, were supported by testimony before Legislative Committees.

4. The State Board of Health PKU mass screening project was supported by the Society.

5. The Society through its Committees on Nursing and Legislation; participated extensively in several draft revisions of a bill re-writing the Nurse Practice Act. Many suggestions of the Society were incorporated into the final draft of the bill, which was then enacted with Society endorsement.

6. As reported in the 1965 Annual Report, the Society sponsored legislation designed to provide some measure of state subsidy to the hospital-based, 3-year, Diploma Schools of Nursing. This bill was not enacted, failing by the narrowest of margins, but considerable public and legislative attention was directed to the plight of their 3-year Schools of Nursing, which now supply 90 per cent of the practicing R.N.'s for this state. The Assembly did enact a resolution directing the Legislative Research Study Commission to study the entire problem of para-medical manpower needs and training, including nurse education, and to prepare suggested legislation for the 1967 General Assembly. The Society will present testimony at the hearings before the Legislative Research Study Commission.

7. The Committee was consulted by several legislators in regard to proposed legislation sought by

the N. C. Psychological Association; which would have provided for the certification and licensure of psychologists. Feeling that certain sections of the proposal would lead to the practice of medicine by psychologists, the Committee suggested certain amendments and deletions, which were considered reasonable and proper by the Legislators involved. However, the psychologists refused to accept these changes, whereupon their legislative support was withdrawn, and the bill was never introduced.

8. A bill designed to re-define Chiropractic and to broaden the practice of Chiropractic was introduced and the defeat of this measure by very narrow margin required a considerable effort. It is learned that the Chiropractic group is already busy preparing a similar proposal for the 1967 General Assembly.

9. The Optometrists were successful in securing enactment of a bill, opposed by the Society, to provide for payment of optometric services under various insurance programs and governmental health care programs, where such programs provided benefits for services which could be rendered by optometrists. The Society was successful in having the original bill substantially amended in Committee prior to enactment.

10. The Society took no official stand on a bill sponsored by the N. C. Dental Society, which requires voluntary and commercial health insurance carriers to make payment to dentists for professional services rendered by them, and for which payment would have been made had the services been rendered by a physician. This bill was enacted.

11. The Society supported a bill, subsequently enacted, which was sponsored by the State Bureau of Investigation and which was designed to curb the illicit traffic in certain potent drugs within the State.

12. The Committee participated in the drafting of a bill, subsequently enacted, providing for the establishment of a Governor's Coordinating Council on Aging within the Department of Administration. This agency will administer grant funds made available under Title III of the federal law "The Older Americans Act of 1965".

Many other items of lesser importance, too numerous to recount here, were considered and acted upon by the Committee.

B. National Legislation

1. Medicare (PL 89-97). As was predicted in the previous report, medicine was finally defeated in its long and arduous fight which we have waged for two decades to prevent the enactment of compulsory health insurance in the United States. It is with pride that we record the fact that the entire North Carolina Congressional Delegation; Congressmen and Senators alike, supported the policies of medicine in the key votes on the issue. The bill as enacted, provides benefits for hospitalization and for physicians' services to the over 65 age group, including self-employed physicians under

Social Security, creates a new tax rate schedule for Social Security, and also greatly extends welfare health care programs to the indigent and medically indigent of all age groups. Because of the momentous impact of this legislation, its implication and its effect on future legislative policies of our profession have been subjected to detailed analysis and re-evaluation in countless conferences, articles in medical journals, addresses at medical meetings, etc. Because this analysis and evaluation is being continued, a more detailed analysis of medicare will not be attempted in this report.

2. Animal Research—many bills have been introduced into the Congress for the purpose of regulating the acquisition, transportation, sale, and handling of animals to be used for teaching or research. Many of these bills contained provision which would, in effect, subject medical research to complete Federal domination. The Committee has maintained close liaison with the 3 medical schools within the State in their Study of this bill, and the Society presented documentary testimony to the Congressional Committee, outlining the position of the Society and the three medical schools.

3. Heart, Cancer, Stroke—Congress enacted a greatly modified version of this proposal, which would establish regional centers for post-graduate and continuation education, research, and demonstration projects in the area of these disease categories. The Society opposed the bill in its original form and our objections were transmitted to our Congressional Delegation. The Society is playing an important role in the orientation and implementation of the program, as enacted, in North Carolina.

Many other items of national legislative importance were considered and our efforts were coordinated with those of the AMA.

C. Other Committee Activities

The Committee has participated extensively with other Society Committees in consideration of items with implication for legislation. Committee members have participated in over 150 programs before county societies, other medical groups, civic organizations, etc. Several TV and radio programs have involved the Committee in discussions involving legislation. Research has been done as requested to provide for legislation. A pleasant and profitable relationship has been developed with the Institute of Government. Several issues of a new publication, "Legislative News", have gone out to Society members to bring news of current developments. The Committee has been represented at several AMA conferences on legislation.

The Chairman again expresses his deep and sincere gratitude to the entire headquarters staff, to John Anderson, Jim Barnes, Bill Hilliard, the other members of the Committee, and to physicians all across the state all of whom have contributed so much to these efforts in the cause of medicine.

Edgar T. Beddingfield, M.D., Chairman

DIVISION OF NATIONAL LEGISLATION

The Division of National Legislation has no report that is not encompassed in the report on the Committee on Legislation by Dr. Beddingfield.

Donald B. Koonce, M. D., Chairman

DIVISION ON DOCUMENTARY PRESENTATIONS

There is no report in that this Committee did not function in 1965.

Hubert McN. Poteat, Jr., M. D., Chairman

COMMITTEE ADVISORY TO MARRIAGE COUNSELLING

I hereby submit the report of the Committee Advisory to Marriage Counselling. In August the members of the Committee on Marriage Counselling met in Morehead and made tentative plans for the Professional Education meeting to be held in Chapel Hill on May the 21 and 22.

Dr. Marianna Breslin and Dr. Charles Flowers were appointed Co-Chairmen for the meeting. Dr. Eleanor Easley, Watts Hospital, Durham, North Carolina; Dr. Hans Lowenbach, Duke Hospital, Durham, North Carolina; and Dr. Eugene Linton, Bowman Gray School of Medicine, Winston-Salem, North Carolina; composed the Committee with myself as ex-officio member. This Committee has planned an excellent Professional Education meeting to be held at Chapel Hill on the above dates, with outstanding speakers on early marriage and the advent of the first pregnancy to the birth of the first child.

The Committee on Marriage Counselling invited Dr. George Paschal and Dr. J. W. Norton to join them in a meeting and discussed with them the possibility of organizing a new department in the State Department of Public Health to be known as the "Department of Family Living."

The idea was presented to the September meeting of the Executive Council of the State Medical Society. It was approved and referred back for suggested implementation.

Another Committee meeting was called in Chapel Hill Dec. 1966 and a detailed outline for implementing the suggested new department of our Public Health was made. After the plans were approved by the Committee, the plans were accepted by Dr. J. W. Norton, the State Health Officer, and he assured as Dr. Jacob Koomen, his successor, would also be in sympathy with this plan.

The plans for implementing the Family Living Division of the State Department of Public Health was presented to the Mid-winter meeting at Pinehurst and accepted.

This has been a very active Committee. We feel that the Professional Education meetings that were held last year in Winston-Salem and this one to be held in Chapel Hill have been of great value to the General Practitioners, the Obstetricians, Gynecologists and to our allied Professions, particularly the

ministers and Social Workers of the State who are interested in the field of Marriage Counselling and Pre-marital Education. These Professional Education meetings are easy to program. Guest speakers are anxious to come, guest speakers of excellent caliber. We do not feel that we can invite these speakers without offering financial remuneration for their time given and their expenses incurred, hence, we would like to suggest to the Medical Society that if possible they allocate at least \$500.00 a year to this meeting; or would it be possible to organize this as part of the Extension Division for Continuing Adult Education under the University of North Carolina; or should this become the responsibility of the State Department of Public Health? These are questions which we think should be answered.

Rachel Davis, M. D., Chairman

COMMITTEE ON MATERNAL HEALTH

The Committee through the year 1965 has diligently pursued its original objectives to improve the total care for all women of the child-bearing age and particularly to urge the promotion of adequate prenatal care and a safe labor and delivery for all pregnant women in North Carolina. During this past year there has been considerable cooperative effort between the Maternal Health Committee and the Committee on Marriage Counseling with Dr. Rachel Davis, Chairman, as well as the School Health Committee. Through the cooperative efforts of these Committees the State Board of Health has agreed to consider the development of a "Division of Family Living". Through the instruction of the Maternal Health Committee members, the Chairman of the Committee on Maternal Health met with the Committees on Mental Health, Medicine and Religion, School Health, Child Health, and Marriage Counseling to have included in the report of the North Carolina Mental Health Association's publication, **MENTAL HEALTH SERVICES FOR CHILDREN**, a section concerning the urgency of introducing family life education in the public school curriculum as a matter of preventive mental health for young children who may never receive any objective family life orientation other than that which they would get in the public schools. This resolution was presented at the meeting of the above joint Committees and was included as a section in the Report on Mental Health Services for Children.

A total of eighty-one (81) maternal deaths was recorded in the records of the Maternal Health Committee during the year 1965. These appear tabulated in Table I. Hemorrhage and toxemia lead the list of maternal deaths with twelve (12) each. Embolism was thought to be the cause of death in nine (9) cases and infection and cardiac conditions were responsible for six (6) each. Other intercurrent obstetrical conditions were recorded in seven (7) cases and twenty-six (26) were non-obstetrical deaths due to accidental causes and other intercurrent medical conditions.

Forty-three (43) counties reported maternal deaths in 1965. Most of these reported only one or two deaths each. It is notable that the larger population centers have the larger number of maternal deaths. This is tabulated in Table II showing Mecklenberg having eight (8), Forsyth seven (7), Orange six (6) and Durham County four (4) maternal deaths. One might note that the usual two-to-one colored-to-white maternal deaths does not prevail in the 1965 data. The eighty-one (81) deaths for 1965 represent a decrease from one hundred six (106) in 1964. However, the thirty-two (32) white deaths represent a decrease of three (3) while the forty-nine (49) colored represent a decrease of twenty (20) for the year 1965 over the year 1964. Statistical data for deliveries in 1965 are not available. However, for 1964 there was a total of 99,774 live births, representing a decrease of 1,474 over the total 100,248 live births for 1963.

The Chairman of the Maternal Health Committee has participated in at least four significant programs during the year. In April 1965 the Chairman conducted a round table discussion at the Annual Clinical Meeting of the American College of Obstetricians and Gynecologists in San Francisco, California, entitled "The Leadership Role of the Maternal Health Committee in the Practice of Obstetrics". This consisted chiefly of a presentation of the activity of the Committee on Maternal Health of the Medical Society of the State of North Carolina through the past fifteen years. The Chairman, along with member Dr. James F. Donnelly, served on the faculty of the Southern Obstetrical Seminar in Asheville for a week in July 1965. In September the Chairman delivered a paper on "Septic Abortion and Endotoxin Shock" at the Seaboard Obstetrical Society in Wilson, N. C., and in October conducted a symposium on "Family Life Education" at the Annual Convention of the North Carolina Family Life Council.

The Chairman of the Maternal Health Committee wishes to thank the members of the Committee for their fine cooperation in assisting him in carrying on the work of the Committee and also wishes to express appreciation to the President, the Executive Council and staff of the Medical Society of the State of North Carolina for their continued interest and strong support of the Committee on Maternal Health.

TABLE I

		White	Colored
Hemorrhage	12	4	8
Infection	6	0	6
Toxemia	12	3	9
Cardiac	6	4	2
Embolism	9	4	5
Anesthesia	2	1	1
OOB	7	4	3
NOB	26	11	15
Not Classified	1	1	0
	81	32	49

TABLE II

County	Total	OB	Non-OB	White	Col.
Mecklenberg	8	6	2	5	3
Forsyth	7	5	2	1	6
Orange	6	3	3	2	4
Durham	4	2	2	2	2
	25	16	9	10	15

Financial Report

Balance 7-1-65		\$1,382.61
Receipts 7-1-65 / 1-31-66		0
Expenditures 7-1-65 / 1-31-66		
Personnel	\$1,251.29	
Supplies	442.39	1,693.68
Balance 1-31-66 (overdraft)		(311.07)
Personnel—July and August	325.00	
September	185.00	
October-January	700.00	
	1,210.00	

W. Joseph May, M.D., Chairman

MEDICAL-LEGAL COMMITTEE

1. Review of work done to date:
The Medical-Legal Committee met in Pinehurst on September 24th, 1965, with five committee members present. Matters considered at that time included five committee members present. Matters considered at that time included a request from the North Carolina State Nurses Association in regard to the application of emergency closed chest cardio pulmonary resustitation by a nurse; the matter of a physician selecting patients whom he wishes to treat while he is on duty in the emergency rooms; and the problem of having to fill out an increasing number of insurance forms. It was the feeling of the committee that the practice of having one joint meeting of the Medical-Legal Committees of the Medical Society and the North Carolina Bar Association per year be continued. Problems which had arisen in the discussions at joint meetings at the county level were described. A joint meeting of the Medical-Legal Committee of the Medical Society and North Carolina Bar Association is planned for May. The chairman has participated in discussions with Mr. R. L. Brown, Jr., Attorney at Law, Albemarle, Chairman of the Medical-Legal Committee of the North Carolina Bar Association, in regard to a joint meeting and such a meeting is scheduled for May.
The Committee will participate in the "Medical Legal Day" to be sponsored by the Student Medical Association of Bowman Gray School of Medicine and the Student Bar Association of the Wake Forest Law School on March 22nd. Mr. Edwin Holman of the Legal Department of the American Medical Association is to appear on the program.
Joint meetings were held in twenty counties during the past year. Meetings were conducted by the Chairman in Hickory, Morganton, Char-

lotte and Wadesboro. In addition, medical-legal subjects were discussed before paramedical groups in Charlotte and Winston-Salem.

2. Unethical Actions:

No instance of alleged unethical conduct on the part of the physicians has been reported to the committee.

3. Recommendations for the future:

Closer cooperation between the Medical-Legal Committees of the Medical Society and the North Carolina Bar Association. This would include the sponsoring of more joint meetings at the county level.

Standardized physical form for high school students who participate on athletic teams. This project is now being undertaken.

Julius A. Howell, M.D., Chairman

COMMITTEE ON MILITARY DEPENDENTS MEDICAL CARE

The Military Dependents' Program operated on a fairly stable basis throughout the year 1965 as evidenced by a comparison of the number of physicians' claims and the amounts paid during the years 1964 and 1965, respectively. For the first time in several years, there was a small decrease in the number of claims paid; which is probably due to the transfer of active-duty troops from North Carolina to foreign duty—dispersing their families to other states. The benefit provisions of the Program remain unchanged with only minor adjustment being made in the contracted Schedule of Maximum Allowances. During the year a contract amendment was negotiated with the Director of the Office for Dependents' Medical Care, a division of the Office of the Surgeon General, permitting distribution of the Fee Schedule. Our Fiscal Agent will print these Schedules and distribution will be to new physicians and others upon request.

The Committee is very much aware that the Schedule of Maximum Allowances has been in effect for nine years without change. I was instructed to begin negotiation for a modernization of the Schedule. With the cooperation of Hospital Saving Association, considerable data has been compiled as to the average amount paid for services and the conversion factor necessary to achieve various levels of upgrading under the North Carolina Relative Value Schedule. The Committee will pursue this as a priority objective during 1966 with the guidance of the Executive Council and officers of the Medical Society.

The annual report for 1965 from our Fiscal Administrator, Hospital Saving Association which is attached, is incorporated as a part of the Committee report and gives comparative statistics for the past two years. The report indicates that over the past nine years a total of \$18,033,464 has been paid to North Carolina physicians and hospitals—

a significant factor in support of community hospitals and free choice of private physicians.

Our relationship with the Office for Dependents' Medical Care has been satisfactory and the Committee expresses its appreciation to Brigadier General Norman E. Peatfield for the cooperation given in the administration of the Program.

The Committee has held meetings as needed and the chairman and members have consulted with each other by telephone and letter frequently; thus, cases of unusual and complex nature were considered individually and settled to the mutual satisfaction of those involved.

Hospital Saving Association has continued to give excellent cooperation and administration. The counsel and aid of Mr. James T. Barnes and his staff at the Headquarters Office of the Medical Society have been invaluable.

The Committee recommends to the House of Delegates that the Medical Society continue to contract with the Government in the operation of the Military Dependents' Program subject to revision, modification, or discontinuance by the Executive Council as events might indicate.

D. M. Cogdell, M.D., Chairman

ANNUAL REPORT—1965

To the Committee on Military Dependents' Medical Care of the Medical Society of the State of North Carolina

From

Hospital Saving Association
Chapel Hill, North Carolina

Hospital Saving Association has completed its ninth year as Fiscal Agent for the Medical Society of the State of North Carolina under a Contract to reimburse physicians for civilian medical care provided the wives and children of active-duty servicemen. During the period 1957 through 1965, \$9,316,618 was paid to North Carolina physicians for 113,563 case reports. Under separate Contract, the Association reimburses hospitals for care provided military dependents who are eligible to receive benefits. From 1957 through 1965, \$8,716,846 was paid to North Carolina hospitals for 84,549 claims. The total amount paid for all care since the beginning of the Program is \$18,033,464 for 198,112 case reports. Comparative statistics for physician payments for the years 1964 and 1965 are as follows:

	1964	1965
Amount Paid to Physicians	\$1,042,554	\$936,463
Number of Cases	12,677	11,575

We take this opportunity to express our sincere appreciation and gratitude to the Committee on Military Dependents' Care, its chairman—D. M. Cogdell, M.D., and to Mr. James T. Barnes, Executive Director of the Medical Society of the State

of North Carolina, for the cooperation and guidance in the administration of the Military Dependents' Program.

Respectfully submitted,

K. G. Beeston, Director

Professional and Government Relations

E. B. Crawford, President

Date: February 18, 1966

COMMITTEE ON MENTAL HEALTH AND MEDICINE AND RELIGION

This has been a very active year for the Committee on Mental Health and Medicine and Religion. The activities have been carried out through the very active programs of the subcommittees with Dr. Charles Vernon, Chairman of Mental Health Education; Dr. Lloyd J. Thompson, Chairman of Mental Retardation and Children's Services; Dr. Hamilton Stevens, Chairman of Alcoholism; and Dr. Jack Wilkerson, Chairman of Medicine and Religion.

To update the committee structure, several slight changes in the subcommittees were made this year. Since mental retardation is receiving so much emphasis now and the aegis of mental retardation is by a subcommittee of the AMA Committee on Mental Health, and there is a need for increased physician participation in mental retardation, the name of the Subcommittee on Children's Services be changed to the Subcommittee on Mental Retardation and Children's Services. To improve coordination and communication, representatives on the following related committees, respectively, were appointed to be shared with each of the Child Health Committee, School Health Committee, Maternal Health Committee, and Marriage Counseling. The previous subcommittees on Physician Education and Public Education were combined to form the Subcommittee on Mental Health Education to eliminate overlapping areas of concern.

Each of the subcommittees have held a meeting this year, and most of them have had two meetings. In an effort to improve communications and broaden representation, Dr. John Reece was appointed to the committee as a representative from the Mental Health Advisory Council to the State Board of Mental Health. Dr. Leon Robertson (Chairman of the Committee on Mental Health of the North Carolina Academy of General Practice) was appointed as a representative from the Academy of General Practice and Dr. Phillip Nelson, already a member of this committee, was designated to represent the North Carolina Neuropsychiatric Association.

General

I represented the Committee on Mental Health of the Medical Society of the State of North Carolina at the National Conference on Community Mental Health Programs co-sponsored by the National Institute of Mental Health and the Council of State Governments which was held at the Sheraton-Chicago Hotel in Chicago, December 13 through 15,

1965. Our committee supported the resolution from the Committee on Marriage Counseling that a Family Life Division in the North Carolina Department of Health be created. This division would assure close cooperation of all health agencies concerned in the provision of service for family life. Our committee stressed that a representative from the Mental Health Department be included in some type of advisory capacity in the development program for the Family Life Division.

Our committee recommended that one issue of the North Carolina Medical Journal in 1967 be devoted to the topic of psychiatry. Tentative approval has been granted this request, but no definite date has been assigned our committee for this issue.

The Mental Health and Law brochure has been prepared and approved by the Attorney General of the State of North Carolina, the Medical Society of the State of North Carolina Executive Committee, the Board of Directors of the North Carolina Mental Health Association and the North Carolina Department of Mental Health. Final approval for this brochure is anticipated at the meeting of the Board of Governors of the North Carolina Bar Association at its meeting on 4-15-66.

Mental Health Education Subcommittee—

Dr. Charles R. Vernon, Chairman

A shop-talk on suicide was prepared last year and is now ready as a program.

The Telephonorama Project or Project to promote Programs on Mental Health and Medicine and Religion for county medical societies has been very well received. Funds to promote this project for county medical societies have been obtained from the American Medical Association and three pharmaceutical houses. Our goal for this year is two programs on mental health and medicine and religion in each county medical society this year.

The Medical Society was co-sponsor for the Third Annual John W. Umstead Series of Distinguished Lectures which was held in February in Raleigh.

On February 19 through 21, a training session for the practitioner and non-psychiatrist was held, in cooperation with the North Carolina Academy of General Practice and the North Carolina Neuropsychiatric Association with assist of a grant from the National Institute of Health as obtained by Dr. D. A. McLaurin.

Mental Retardation and Children's Services

Subcommittee—Dr. L. J. Thompson, Chairman

This committee was very active in that the final report on the Mental Health Services for Children in North Carolina was finally approved by the Executive Council of the Medical Society. Three thousand copies already have been distributed and two thousand extra copies from a second printing are now ready. This subcommittee is actively striving to launch a program to interest and involve physicians in the problem of mental retardation in North Carolina.

Alcoholism Subcommittee—Dr. Hamilton Stevens, Chairman

A proposed policy statement on alcoholism was drawn up by this subcommittee and is being passed around now for review by the various committees of the Medical Society with a concern in the area of alcoholism. It is to be submitted to the Executive Council for approval at its next meeting.

A memorandum is being sent to the representative physicians in county medical societies which are "wet counties" to inform them of the availability of 5% of the gross sales of alcoholic beverages for implementation of a local program on alcoholic education.

Religion Subcommittee—Dr. Jack Wilkerson, Chairman

A seminar on Medicine and Religion is being planned for the spring of 1967 with Dr. Jack Wilkerson and Rev. Fred Reid serving as co-chairmen.

Dr. Paul McCleave addressed the Annual Officer's Conference at a luncheon meeting during its recent meeting in January in Pinehurst. His talk was most well received.

An exhibit on Medicine and Religion has been arranged to be shown at the Scientific Exhibit at the Annual Meeting of the Medical Society of the State of North Carolina in Asheville this year. Members of the committee, as well as others, are assisting with the servicing of this booth at the Annual Meeting.

A newsletter is being prepared on medicine and religion for distribution to the various county medical societies.

Because of the magnitude of the program on medicine and religion and its tenuous relationship to mental health, Dr. Frank Jones, President-elect of the Medical Society of the State of North Carolina, was contacted with the request that next year the concern of Medicine and Religion receive a committee status and that it be removed from the present Committee on Mental Health and Medicine and Religion. The reaction to this request has not been received at this time.

John L. McCain, M. D., Chairman

SUBCOMMITTEE ON MENTAL HEALTH EDUCATION

The Subcommittee has continued its efforts to coordinate physician mental health education throughout the state. Cooperation with the North Carolina Mental Health Association, North Carolina Neuropsychiatric Association, the Academy of General Practice, and the U.N.C. Continuation Education have made this possible.

The "shoptalk" on suicide which was developed by the Academy of General Practice in cooperation with the Medical Society has been completed and is being utilized in the Medical Society's efforts to develop a speakers bureau program for North Carolina.

Seminars for nonpsychiatrist physicians continue to be held at Chapel Hill through the Continuation Education Division of the School of Medicine. An every-other-week, 10-week seminar series makes up this program. Seven physicians are presently enrolled, and five physicians were enrolled last year in this series.

Telephonorama: A speakers bureau has been developed by this subcommittee through the Medical Society's executive offices. A section of the state has been assigned each subcommittee member for him to make personal contact with the program chairmen of local medical societies for mental health speakers throughout the year. Financial support is forthcoming for this and, hopefully, this will be continued if it proves to be a satisfactory mechanism for such an endeavor over the next two years.

The Medical Society cooperated with the State Department of Mental Health and the Mental Health Association to sponsor the Third Annual John W. Umstead Series of Distinguished Lectures, February 3-4, 1966.

Charles R. Vernon, M.D., Chairman

SUBCOMMITTEE ON MENTAL RETARDATION AND CHILDREN'S SERVICES

The report of this subcommittee entitled Mental Health Services for Children was published in pamphlet form in December 1965. This was a joint report of committees from the North Carolina Mental Health Association and the Medical Society of the State of North Carolina. An introductory statement said, "To our knowledge, this is the first cooperative and comprehensive report by a state medical society and a state mental health association concerned solely with the improvement of mental health of children in its boundaries."

The report was distributed widely within the state and nationally to key people in the various disciplines that are concerned with the mental health of children. Particularly, a copy was sent to the president of each county medical society and to the chairman of his committee on mental health. An accompanying letter urged use of the report in educational activities and the planning for action in local medical societies. A return postal card made it possible for the county medical society to express interest in various aspects of the field and to ask for assistance in educational programs.

The original printing of 3,000 copies of this report has been exhausted and 2,000 more are being produced. Copies are available on request through the offices of the Medical Society of the State of North Carolina or the North Carolina Mental Health Association.

When the term "mental retardation" was added to the name of this subcommittee last year it was proposed that we formulate a report on mental retardation patterned after the one on children's services. However, it was found that the report of

the A.M.A. Conference on Mental Retardation published in the JAMA, 1/18/65, contained practically all the medical information available. This material was issued later by the A.M.A. in a booklet entitled Mental Retardation: A Handbook for the Primary Physician. Also, the North Carolina Council on Mental Retardation will publish their report on comprehensive planning for the mentally retarded in the near future. Therefore, another publication in this field for the medical profession appears to be unnecessary at this time.

Your chairman has contacted Mr. Robert L. Denny, Executive Director of the Council on Mental Retardation concerning the distribution of the above mentioned publications and other material to the key people in the county medical societies. It is recognized that the State Board of Health and other agencies are concerned with enlisting the interest and leadership of practicing physicians in better community services for the mentally retarded. However, this subcommittee will continue its efforts to interest physicians in becoming more concerned about this problem in their daily practice.

Lloyd J. Thompson, M. D., Chairman

SUBCOMMITTEE ON MEDICINE & RELIGION

The Medical and Religion subcommittee of the Committee on Mental Health has held three meetings in 1965-66. These meetings were well attended and definite action plans have been formulated. The committee members met in Raleigh, N. C. on September 2, 1965, Nov. 18, 1965 and Feb. 24, 1966. Representatives from the AMA Department of Medicine and Religion met with the committee in September and November.

The objective of the M & R committee has been to interest, inform and help create a climate by the members of the Medical Society of the State of North Carolina to bring about a closer understanding with the members of the clergy in their respective local areas.

There have been at least four joint meetings between county medical societies and clergymen to date. Other meetings are being planned. This committee has worked with the Mental Health committee to provide a speakers bureau and subjects for county medical society programs under the cooperative "TELEPHONERAMA" project of the above committee.

Dr. Paul B. McCleave, Director of the AMA Department of Medicine and Religion was obtained to speak at the Annual State Officers Conference in Pinehurst, N. C. January 29, 1966.

The Medicine and Religion Committee has felt that it should be a separate committee of the Medical Society. Efforts have been made to bring about this separation in a brief sent to President-elect Frank Jones. Dr. John McCain was responsible for doing considerable background research and documentation in the preparation of the brief.

The M & R Committee has made arrangements

to have an exhibit at the Annual meeting of the Medical Society of North Carolina in Asheville May 1-4, 1966. The exhibit is to be manned by members of the committee and local clergymen.

During the year plans have been discussed and formulated to sponsor a statewide Symposium on Medicine and Religion in early 1967. This is to be a two and one-half day meeting at Chapel Hill with nationally known participants. This will be the first such symposium to be held in the Southeastern section of the United States.

A proposed Medicine and Religion Newsletter for county society presidents, program chairmen and mental health chairmen is about ready for its initial distribution. It is hoped this can be a semi-annual publication to inform and publicize the work of this committee and the activities of local county medical societies in the field of Medicine and Religion.

Jack W. Wilkerson, M.D., Chairman

ADVISORY COMMITTEE TO THE N. C. DEPARTMENT OF MOTOR VEHICLES

Since the inception of the medical examination in May 1964 through March 3, 1966, this committee through its thirty unidentified physicians has reviewed 2,504 cases. Of this group, the committee has recommended that twelve and a half per cent not be approved for an operator's license in North Carolina for medical reasons. Only three and a half per cent of the people referred have been found to have no medical disease. Some thirty per cent of the people, who have been referred for examination, have been referred for mental problems. The next two largest groups in order are neurological disorders and alcoholism. We are presently in the process of analyzing the data which has been obtained in more detail through the co-operation of Dr. Charles M. Cameron, Jr., U. S. P. H. We hope to be able to present an addendum to this report by the time the House of Delegates meets which will spell out our results in more detail.

We are in the process of revising the medical examination form so that the information obtained can be more easily transferred to a computer.

We are most appreciative of the information provided to us by the family physicians and we urge each physician, who has an examination of this type to perform, to give us all the information which is required on the examination. In North Carolina, we are in a unique position of having a computer system available to us which will allow us to study in detail the results which we obtain. No other state in the union, even though they may have a medical review board, is in this position.

Our committee is most appreciative of the time and the interest which the thirty unidentified consulting physicians have given to this program and we sincerely hope that their interest and help will continue. As this program grows, we will seek additional physicians to help us in this evaluation.

North Carolina is third from the bottom in traffic safety and in traffic deaths. We feel that this program has a tremendous potential in helping the Department of Motor Vehicles remove from the driving population those people who for medical reasons should not be driving. We urge your continued support and co-operation.

Simmons I. Patrick, M. D., Chairman

COMMITTEE ON NECROLOGY

The Committee on Necrology will report at the First Meeting of the House of Delegates, Sunday, May 1, 1966.

COMMITTEE ON NEGOTIATIONS

The Committee on Negotiations held no meetings this year, had no problems referred to it, and has no report to make.

William F. Hollister, M.D., Chairman

COMMITTEE OF PHYSICIANS ON NURSING

The Committee of Physicians on Nursing has continued very active during the past year. There have been many meetings which were called by your Committee Chairman from health groups concerned with nursing in the State of North Carolina. The groups most actively interested are the State Nurses Association, the State Hospital Association, the Council on Diploma Schools in North Carolina, the Public Health and Educational Departments.

These meetings have had for consideration mainly nursing education in North Carolina. This matter has had foremost attention for the past two years. The matter of nursing education was neglected for several years previous to this, during the period since 1947 in which the chief matter of interest in the minds of the profession was the building of new hospitals and increasing the hospital beds in the hospitals in North Carolina. This came, of course, as a result of the Hill Burton Act and State Legislation providing funds for this program. As a result the number of beds far outgrew the development of nursing programs to take care of them.

The Committee has been most interested in getting all health groups together in thinking and working in unison towards the development of more Hospital Schools of Nursing.

The project in which the Medical Society through its Committee is most interested is the fate of the Diploma Schools of Nursing which produce over 90 per cent of the nurses which we have in North Carolina.

Since the Ray Brown report on nursing education about two years ago in which he recommended Schools of Nursing functioning under direction of the State Board of Higher Education and supported by tax money, we have been very much concerned on account of the fact that no tax money was suggested for Diploma Schools of Nursing.

Only the Associate and Baccalaureate Degrees were recommended.

In the GUIDELINES for educational facilities for nursing which was worked out by the State Nurses Association in 1965 nothing was said concerning State support for the Diploma Schools of Nursing. In fact, it was intimated that by 1970 most, if not all, of them would be eliminated and we would have Associate and Baccalaureate Degrees, or campus nursing under supervision of the State Board of Higher Education.

The Medical Society and its Committee are interested particularly in the Diploma or Hospital Schools not only on account of the great shortage of nurses which would probably be accentuated in the change over to the Associate and Baccalaureate Degrees, but probably would decrease the practical efficiency of nurses.

As a matter of fact, the Medical Society is in favor of Associate and Baccalaureate Degrees programs and are willing to cooperate in every way that we can with the nursing profession to promote nursing education, and any condition which might better the preparation, the remuneration, and the personal satisfaction of nurses. We feel, however, that this could all be accomplished as well in the Diploma Schools of Nursing. In order to do so it would be necessary for these Schools to have financial aid from the State in order to have better equipment and well trained and well recognized teachers. Under the present conditions it is impossible for the Schools to do this on their own. We feel they need and should have State aid along with the Associate and Baccalaureate Schools of Nursing.

There are many other factors which come to bear and make for an unfair competition for the Diploma Schools, such as the attraction of the campus for most young people who are in whatever course of training, and the prestige which college affiliation gives them. In many of the Diploma Schools, however, more academic work can be done in connection with colleges which are situated close by, and especially in the new community colleges which are being built so that the student would have ample time for her social and general education and not be taken away so much from the bedside or practical training. Another very important point is the matter accreditation which at present seems to be in the hands of League for Nursing as the National Accreditation Board. Their requirements have risen to the point where it is almost impossible for the nurse in the average Diploma Schools to qualify and pass the examination. In this connection serious consideration has been given by the Medical Society for a State Accreditation Agency for Hospital Schools of Nursing rather than a National Accreditation Agency. However, if the Diploma Schools of Nursing are to be accredited financial aid will be necessary.

During the past two years the meetings between the Committee of Physicians on Nursing, the Hospital Association, the Nurses Association, the Hospital Administrators, the Public Health People in North Carolina have been productive of better understanding and more unison in action. Last year a bill asking for a million dollar appropriation was worked out by the Committee of Physicians and introduced in the General Assembly and presented to the Health Committee of the Legislature by the State Society and passed the Committee with favor. However, when it was brought before the Appropriation Committee they passed it to a sub-committee which failed to pass it. Exact causes are unknown. It was charged that it was brought in too late in the press for funds in the late days of the session.

At the present time another Ad Hoc Committee has been appointed from the groups mentioned above to draw up another bill and to find the proper appearance before the Legislative Study Commission to present it. This Ad Hoc Committee is headed by Dr. Ed Beddingfield, Chairman of the Legislative Committee of the North Carolina State Medical Society, our legal counsel and others. So far, no bill has been drawn up, but will no doubt be reported a little later and presented to the Legislature again in 1967. Representatives from all the different health agencies have been appointed and have promised to appear at the Legislative Study Commission hearing when this comes up.

Finally, I would like to say that the Chairman of the Committee of Physicians on Nursing attended the national meeting of representatives from the medical and nursing professions in the United States which was held in Denver September 1965. This meeting concerned itself with the close collaboration between physicians and nurses, and other groups in planning of activities which were of common interest to both groups. The idea was to develop ways and means to communicate with representatives of nursing on a continuing basis, to create a deeper understanding of mutual interests and problems, and undertake all projects with nursing on a colleague to colleague basis. Much valuable information was gained through the discussion groups on matters of interest to both organizations as far as better patient care is concerned. Much was said also about developing organizations on this basis in each state, although this has not been done in North Carolina so far. The State Committee on Patient Care appears to function in this area.

Another point of interest to the members of the Committee and to the State Society I am sure is the fact that Dr. Thomas Hale, an uncompromising and ardent defender of the Diploma Schools, will be on the program of the State Medical Society in Asheville this year. I might mention finally that the Schools on Licensed Practical Nurses in North Carolina are doing a good job and growing rap-

idly, and are doing much to fill the gap due to the shortage of nurses. Furthermore, they are doing a grand job of effectiveness.

I wish to thank the members of the Committee of Physicians on Nursing for their very close cooperation in the work of the Committee during the past year. Also, Dr. Ed Beddingfield, Chairman of the Legislative Committee, who has cooperated with all our deliberations and proposals. We have had unusual support also from the Headquarters office by Mr. James T. Barnes and Miss Kay Zeigler.

Fred C. Hubbard, M.D., Chairman

SUBCOMMITTEE ON NURSING AND PATIENT CARE

This has been a very active year for the N. C. Nursing and Patient Care Committee with follow-through being made on many existing projects and several new projects undertaken.

Hospital Visitation Study

Concerned with the misuse of hospital visiting, the committee initiated a joint statement of purpose regarding visitating which was formally approved by the major health disciplines. The agreement provided for individual and joint sponsorship of a program to provide an understanding of the need of acceptance of proper visiting controls. Using a study performed by the Department of Hospital Administration at the University of N. C. as a guideline, the visitation problem in the state was reviewed and an application was made for the support of "Two Test Projects to Improve Visiting Practice in N. C. Hospitals", to be carried out by this committee in cooperation with the Department of Hospital Administration of the U. N. C. School of Medicine. These needed funds have been requested from the United Medical Research Foundation, but final action on this request is not available at this time.

"I Am Your Patient" Brochure

From the viewpoint of the patient, this brochure has been offered at cost to hospitals throughout the state as a continuing service since last year. More than 35,000 copies have been purchased by hospitals for dissemination to nurses and other employees.

"Mrs. Reynolds Needs a Nurse"—Film

The Committee obtained this film from Smith, Kline and French Laboratories for showings to personnel in patient care over the state. Arrangements were made for the film to be distributed by the State Board of Health. Special promotion for the film was carried out through related health organizations across the state. The response to this film has been overwhelming, and two more additional prints of the film have been requested by the State Health Department to shorten the waiting time of two months to receive a copy of the film for showing.

Brochure About The Committee

A descriptive brochure about this committee was prepared, and seven hundred copies of this brochure

have been distributed across the state. This booklet describes the history, objectives, membership, officers, committees, meetings, program topics, and projects of this committee, as well as a list of the membership.

Emergency Health Identification

A program to promote persons carrying health identification information is underway which includes the following: A) Notes were sent to the N. C. Highway Department, and the N. C. Division of the American College of Surgeons commending them for including a health questionnaire on the back of driver licenses. B) Recommendations were also made to the appropriate agencies that such information also be requested on the back of Medicare recipients' cards and Blue Shield-Blue Cross identification cards.

Formation of Patient Care Committee Function Encouraged

A brochure is being prepared describing the functions of nursing and patient care committee, stressing the importance of cooperative attitude between the major health discipline at the local level in providing health services.

Community Health Services

Projects to promote improved community health resources including the following:

A) A memorandum was sent to the hospital administrators across the state encouraging them to have compiled community health resource directories in which all the health resources at the local level for each county is listed in an easily readable and accessible fashion.

B) The State Board of Health and the other agencies concerned with the Medicare services were written stressing the importance of the need of a local health resource person to be available to instruct Medicare applicants and recipients, as well as others in need of health services, as to what services are available, where they are available, and how they can be obtained.

Financial Report

The work of this committee is financed by voluntary contributions from the parent agencies of the committee members. Twenty-five dollars was received last year from the Medical Society of the State of N. C., toward the work of this committee.

John L. McCain, M. D.

COMMITTEE ON OCCUPATIONAL HEALTH

The Committee on Occupational Health met at Southern Pines, September, 1965. All committee members had been amply notified of the meeting but attendance was poor.

The discussion centered around a project of long standing; namely, an occupational health program for State employees. Such a program has been worked out by members of this committee but implementation continues to be the problem. The committee agrees that such a program should be under

the direction of the Occupational Health Section of the State Board of Health. The committee also agrees that the Occupational Health Section should not be a part of the Epidemiology Division which is directed by a doctor of Veterinary medicine. Therefore, it is the consensus of this committee that such a proposal for State employees be withheld until such time as this organizational setup can be modified.

It was determined that the battery of screening examinations for physicians attending the State Society meeting were too expensive to be practical or well accepted. This project was, therefore, dropped.

B. W. Goodman, M.D., Chairman

COMMITTEE LIAISON TO THE NORTH CAROLINA PHARMACEUTICAL ASSOCIATION

The Committee Liaison to the North Carolina Pharmaceutical Association has met several times during the year. We have been concerned primarily with the implementation with the Kerr-Mills Drug Program and its relationship to the practice of medicine. This Committee has served in an advisory capacity to the State Board of Public Welfare. We are gratified at the success of the Program thus far and are continuing to recommend improvements as we gain more experience with the Program.

The Committee has adopted a statement on interprofessional relationships which the Executive Council approved at their January meeting. This has been submitted to the North Carolina Pharmaceutical Association for their approval, in which case it will be widely distributed to members of both professions. It is sincerely hoped that members of the Medical Society will agree with and support the ideals of this Code.

The Committee has attempted to stay abreast of the many changes affecting prescription drugs and the affect on prescribing physicians. Through the public relations staff, members of the society have been made aware of the changes brought about by Federal Legislation known as HR 2, which deals with amphetamines and barbiturates and other depressant or stimulant drugs. We feel that all members of the society should by now be fully alert to their responsibilities under this new law.

We have met with the Committee on Chronic Illness and with representatives of the North Carolina State Nurses' Association, The North Carolina Board of Pharmacy, The North Carolina Pharmaceutical Association, and The North Carolina State Board of Health to study the problem of emergency drugs for use in nursing homes. Since there are certain laws controlling usage of all drugs this particular situation must be handled in a legally approved manner. Final rules and regulations will be under the jurisdiction of the Licensing Agency for nursing homes.

With more and more Federal Legislation in the area of medicine and pharmacy, it seems that the work load for this Committee becomes greater and we need the help and cooperation of all members of the Society.

John T. Dees, M.D., Chairman

COMMITTEE ON PHYSICAL REHABILITATION

The Committee recommended to the Executive Council the establishment of strategically placed centers for the care of amputees where none now exist. Their establishment on a fee-for-service basis with qualified medical and para-medical staffing was advised after evaluating the results of a state-wide sampling of orthopaedic and general surgical opinions carried out by an amputee sub-committee. The first such clinic has since been established in Asheville. Others are in the planning stage.

Opposition was made to HR 8310 (The Vocational Rehabilitation Amendments Act of 1965), particularly the elimination of the financial needs requirement for the acceptance of Vocational Rehabilitation clients. This opposition was carried all the way to the American Medical Association and to Washington, but the Act passed with only token opposition and was signed by the President. North Carolina's Division of Vocational Rehabilitation of the Department of Public Instruction has retained its "means clause" to date.

Opposition was also expressed by the Committee to the use of different monetary coefficients for services of different specialties in the Fee Schedule, adopted by the Department of Vocational Rehabilitation. A uniform coefficient for all the specialties with adjustment of the number of units for a specific service was thought preferable by the Committee.

Walter S. Hunt, M. D., Chairman

PUBLIC RELATIONS COMMITTEE

The Committee on Public Relations held its annual meeting at Pinehurst on September 23, 1965 and voted to continue the following projects:

1. Support the High School Science Fair and invite an exhibitor from the Biological Division to show his exhibit at the annual State Meeting.
2. Continue the distribution of "Today's Health" magazine to members of the General Assembly, other state officers, and all North Carolina Colleges. A survey of the colleges showed extended usage by the students.
3. Authorize re-editing of "Information Booklet For Physicians" and printing of 1,000 copies to be distributed to all new physicians in the state.
4. Commended the speech training session held in Durham last year and recommended that another session be scheduled during 1966.
5. Continue the Information Booth at North Carolina State Fair for 1966.

6. Encourage County participation in Community Health Week during November.
7. Co-operate with the North Carolina Association of Rescue Squads by providing trophies for their annual convention.

The committee is presently reviewing a guide line and check list for procedures of grievance committees of County Societies. This will be presented after approval by the whole committee to the Executive Council.

The Annual Conference of County Medical Society Officers and Committeemen was held January 28 and 29 at Pinehurst. Although Saturday, the 29th, was the coldest and snowiest day of the winter, I am happy to report that we had a total registration of 142, including 82 physician members representing 41 County Societies. A guide for secretaries was distributed and the Friday evening session was devoted to the indoctrination of newly elected presidents and secretaries. The Saturday sessions were extremely well attended and presented new insights into the problems of communications, ethics, and the threat of Chiropractic legislation, and the afternoon session was devoted to a most instructive and enlightening discussion of public law 89-97 (Medicare).

Your chairman attended the AMA Institute of Public Relations in August which continues to be outstanding in its presentation of all the non-scientific problems facing medicine.

Again our thanks to Bill Hilliard, assistant executive director, and his staff in Raleigh for their excellent work in preparing the Public Relations Bulletin and their most valuable assistance to the Committee in the performance of its functions.

Philip Naumoff, M. D., Chairman

Committee Advisory to the N. C. Department of Public Welfare

The Committee Advisory to the N. C. Department of Public Welfare met twice officially this year. The first meeting was held at the Committee Conclave in Pinehurst on September 23, 1965. The second meeting was at the Sir Walter Hotel on March 8, 1966 with representatives of the Department of Public Welfare.

Interim activities and business of the Committee is conducted by the Chairman and through the offices of the Executive Director, 203 Capital Club Building, Raleigh, N. C.

From time to time, questions regarding welfare eligibility for medical services are received from the public and these are answered and referred to the Department of Public Welfare.

The Committee continues to serve as a sounding board for county medical societies and individual medical society membership regarding questions of welfare programs and particular incidents. Where the Committee has felt it necessary, this is brought to the attention of the proper source in order that some workable solutions can be found.

On several occasions this year, the Committee has informed the Medical Society membership through the monthly Public Relations Bulletin on Welfare Department policy. This was in regard to the availability of the payment from the Department of Public Welfare not to exceed \$5 to physicians for filling out examination reports on persons applying for APTD or AFDC. It was pointed out the county must have funds available to cover the counties part of the \$5.

It was also brought to the attention of the membership that physicians have not been requested to sign non-discrimination pledges in order to receive payment for treatment of patients under state and federally assisted programs.

The Committee continues to keep aware of the trends around the state and country through its liaison with the American Medical Association, other State Medical Societies, and the N. C. Department of Public Welfare. The Chairman, Committee members, other officers and the staff of the Medical Society have attended many meetings throughout the year. The Chairman, has reported from time to time to the Executive Council of the Committee's activities.

The 46th Annual Public Welfare Institute was attended at the Sir Walter Hotel in Raleigh on November 3, 1965. The Chairman attended the Annual Meeting of the N. C. Health Council in Durham on December 7, 1965.

With the passage of Public Law 89-97, the Committee has given considerable attention to this law particularly Title XIX the expanded (Kerr-Mills) welfare medical services program. Due to the inter-relatedness of Title XVIII (Medicare) and Title XIX, meetings have been held with both the N. C. State Board of Health and the N. C. Department of Public Welfare.

The N. C. Conference on the Implementation of Medicare and Related Services sponsored by the Medical Society of the State of N. C., and the Joint Committee on the Health Care of the Chronically Ill and Aging on February 18 and 19, 1966 at the Sir Walter Hotel in Raleigh was participated in by the Chairman and Committee.

At the request of the Commissioner of Welfare, Mr. R. Eugene Brown, this Committee Advisory to the N. C. Department of Public Welfare met with representatives of the Department of Public Welfare to discuss the implementation of Title XIX in N. C. It was the general feeling of those present at this meeting that N. C. would not be ready to go into Title XIX until 1967. Mr. Brown said he would be asking to meet with this Committee from time to time to get their advice regarding the implementation of this law in North Carolina.

Bruce B. Blackmon, M.D., Chairman

THE COMMITTEE

ON RETIREMENT SAVINGS PLAN

In 1965 the NORTH CAROLINA MEDICAL

RETIREMENT SAVINGS PLAN was inaugurated for the benefit of the members of the Society and their employees.

A summary of the chronology of events leading up to this accomplishment is attached to this report.

At the meeting of the Committee at Pinchurst in September 1965 reports were heard and plans were made to inform the membership of the Society about the RETIREMENT SAVINGS PLAN. During the last few months of 1965 a number of illustrated presentations were made to county medical societies over the state about the PLAN. A number of physicians and their employees have begun participation in the PLAN. As of February 1, 1966, 41 physicians and 15 employees have been enrolled in the PLAN and deposits totaled \$89,129.77.

During 1966 the Committee and the Society will continue to make available presentations on the PLAN to county medical societies when invited. Also, long-range plans are being made to keep the advantages of the PLAN before the membership and to inform new members joining the Society about the PLAN. Reports will be made annually and from time to time.

NORTH CAROLINA

MEDICAL RETIREMENT SAVINGS PLAN

Chronology of Events

Inception — Realization

- 1957—Dr. William A. Sams and Dr. J. P. Rousseau presented a resolution which was passed by the House of Delegates indorsing the Jenkins—Keogh Bill.
- 1958—Dr. Lenox D. Baker arranged for the Executive Council to consider matters pertaining to a Retirement Plan.
- 1959—A special committee known as the Trust Study Committee was appointed by President Lenox Baker to follow the Keogh-Simpson Bill and to advise on the feasibility of the Society's sponsoring a Retirement Plan.
- 1959—House of Delegates authorized the Trust Study Committee to act on behalf of the Society to implement the provisions of the Keogh-Simpson Bill if and when passed.
- 1961—Wachovia Bank and Trust Company was selected as Trustee of the PLAN and the Minnesota Mutual Life Insurance Company was selected to handle the annuity portion of the PLAN.
- 1962—Keogh Bill passed by Congress and signed into law on October 12.
- 1963—Plans to implement the NORTH CAROLINA MEDICAL RETIREMENT SAVINGS PLAN were delayed because of lack of guide lines and also a jurisdictional matter between the Securities and Exchange Commission and the Comptroller of Currency.
- 1964—Uncertainties were cleared away and Wachovia began preparation of instruments to create the PLAN. Instruments were studied by lawyers representing all parties.

- 1965—June 28—Master agreement establishing the NORTH CAROLINA MEDICAL RETIREMENT SAVINGS PLAN AND TRUST executed by President George W. Paschal for the Society.
- 1965—September 15—NORTH CAROLINA MEDICAL RETIREMENT SAVINGS PLAN approved by the Internal Revenue Service.
- 1965—October and November—Material distributed and many personal presentations were made to inform the membership on the NORTH CAROLINA MEDICAL RETIREMENT SAVINGS PLAN.
- 1965—December—First deposits received by Wachovia for participation in the PLAN.
- 1966—Participating members now obtaining tax deferment on one half of funds deposited in the PLAN by filing Form 2950 SE with their U. S. Individual Income Tax Returns.
- Jesse Caldwell, M. D., Chairman

COMMITTEE ON RURAL HEALTH

The Committee met in Pinehurst on September 24, 1965 and held two meetings with its advisory committee, one in the spring and one in the fall. The following activities have been carried on by the committee.

- 1) A State Rural Health Conference, planned and sponsored by the committee was held in Raleigh in October, 1965. Many facets related to rural health were discussed at this meeting.
- 2) The committee has continued to encourage 4-H Club Health Improvement Programs by sponsoring one trip to the National 4-H Club Congress for the State Health winner, these certificates to be presented by a member of the county medical societies.
- 3) The committee recommended that TODAY'S HEALTH magazine continue to be furnished to school libraries of the county health king and queen winners.
- 4) Continued emphasis was put on tetanus immunizations. Tetanus immunizations were given in conjunction with the State Health Department in a booth set up at the State Fair during fair week and several hundred people received these immunizations.
- 5) The committee furnished speakers at the Red Cross Aquatic Schools held at Camp Blue Star, Hendersonville, N. C. during the summer.
- 6) A memorandum on pond safety with suggestions for safety devices was sent to all county medical societies.
- 7) The committee has taken cognizance of the fact that the A.M.A. Council on Rural Health's National Rural Health Conference will meet in North Carolina, in Charlotte, in 1967 and has offered all assistance that the committee may give.

Edward L. Boyette, M. D., Chairman

COMMITTEE ON SCHOOL HEALTH

The Committee on School Health of the Medical Society of the State of North Carolina has worked closely with the corresponding committee of the Dental Society of the State of North Carolina throughout the past year on problems relating to the medical and dental health of school children. It has come to our attention that, in addition to the health programs which are carried out by various departments and commissions in the North Carolina State government, there are Federal funds coming from the Federal government to different state organizations for school health purposes. In some cases these funds are directly concerned with school health, whereas in other cases the funds for school health related projects are more or less hidden within the substance of the general grant. Because of the complications of administration of these various sums of money (which amount to several million dollars a year or more), and because of the possibility of overlapping and duplicating programs which proceed independently, the School Health Committee has been most anxious for the past several years in developing (or recommending that there be appointed) a School Health Advisory Committee to the State government. This idea was first proposed in 1962 and was presented to Governor Terry Sanford in June of 1964. Since Governor Sanford was going out of office it was suggested by him and his advisors that the program be presented to the incoming governor. The combined School Health Committees of the State and Medical Society met with Governor Moore in his office in the Spring of 1965 to request that such a committee be formed. This had been cleared with the Governor's legal advisor. After discussing this in general terms with Governor Moore the names of some seventeen persons across the state (representing doctors, dentists, PTA, educators, public health people, and other interested citizens) were suggested to the Governor as persons who would form an active, interested and forceful advisory committee. To date we have had no favorable reply on our request; in fact we feel that the suggestion of an advisory committee to the Governor on School Health has probably been blocked by influential persons at high State level. We are in the process of planning how to proceed to convince the Governor that such an advisory committee is an excellent suggestion, and, in fact, in our opinion, the only sensible way out of a rather difficult situation in which a great deal of money is involved which can be inefficiently spent if the programs are not coordinated.

The most recent case of Federal money for public health is to be found in Public Law 89-10, the Primary and Secondary School Act. Title I of this Act includes provision for health services to the schools. The Department of Public Instruction has proceeded independently to utilize this money without seeking advice or counsel from the Medical

or Dental Society in the best use of these monies and the best use of medical, dental and nursing personnel involved. It was the opinion of our Committee that we were not concerned with the law itself but rather how best it can be implemented in North Carolina. It was felt that it is the Medical Society's responsibility (and, therefore, the responsibility of the Committee on School Health) to see that professional people are not wasted and that all of the School Health programs are coordinated and working together. It is not our function, on the other hand to interfere and intervene in any way in the portion of PL 89-10 which are not concerned with school health.

The Committee on School Health has also been concerned in the past and has discussed during the past year the following subjects:

- (a) Medical aspects of sports.
- (b) A unified personal health and medical record.
- (c) Codes of ethics and code of conduct in athletic relationships.
- (d) School health programs as concerned in other fields such as "Head Start", Cancer, Stroke and Heart Programs, etc.
- (e) Assistance and advice to organizations interested in health careers.
- (f) Sex education in the schools.
- (g) Alcohol education in schools.
- (h) Opposing the sale of soft drinks and sweets in school except as a part of the school lunch program.
- (i) The support of expanded school health programs which incorporate proper safe guards and guide lines for the private physician.

Michael F. Keleher, M. D., Chairman
Committee on School Health
Medical Society of the State of N. C.

COMMITTEE ON SCIENTIFIC WORKS

The Committee on Scientific Works met on September 23, 1965 in Pinehurst for consideration of the Program for the 1966 Annual Meeting. After thorough discussion, the Program was arranged and fully agreed by the members of the Committee.

As a result of the inability of Drs. Wilson and Mayes to participate in the session originally devoted to a discussion of the effect of environmental health centers on medicine in North Carolina, a proposal has been made that this time be given to a discussion of current nursing problems.

David C. Sabiston, Jr., M. D., Chairman

COMMITTEE ADVISORY TO STUDENT AMA CHAPTERS IN N. C. (SAMA)

On May 3, 1965 the Student AMA Chapters of Bowman Gray, University of North Carolina and Duke met with the North Carolina Medical Society. From 3 to 4 P.M. there was a symposium on the medical and surgical therapy of hypertension presented by Drs. Henry Miller, Jim Glenn and T. Franklin Williams. From 4 to 5 P.M. there were

scientific papers presented by students from the University of North Carolina, Duke and Bowman Gray Medical Schools. There was a 7 P.M. dinner meeting at which Dr. George Paschal, President of the State Medical Society was guest speaker and for which Dr. E. J. Hocutt, to be served as chairman.

There have been several meetings since this meeting to plan for the section of the Student AMA Chapters of the North Carolina Medical Society meeting this fall and a good program has been achieved. Students will be the major participants in a panel as well as in the presentation of papers. The evening meeting will include Dr. Ralph Dunn recently returned from voluntary work in Saigon as guest speaker.

Efforts have been continuously made through meetings at all schools and in the committee meetings concerning the planning for the spring program to bring attention of the students to social, legislative and administrative problems of medicine as well as to scientific excellence.

There has been enthusiastic support of the SAMA chapters by the students themselves, by the members of your committee and all other members of the state medical society.

William P. J. Peete, M. D., Chairman

REPORT OF THE COMMITTEE ON UTILIZATION

This report involves the first consideration and action of the organized authorized Committee on Utilization by the Medical Society during the early part of 1965. Formerly this function had been the concern of the Committee on Hospital and Professional Relations. However, during the regime of President Theodore S. Raiford the Medical Society gave new and pointed concern to need for this type of special function for the Society and the Medical profession in the State. President George W. Paschal cited renewed emphasis to the importance of this function when he appointed the Committee in the spring of 1965. Due to this emphasis the Chairman, with the cooperation of the headquarter's staff collected and had referred to it a great amount of material which was studied in depth by the Committee during the summer of 1965.

The Utilization Committee held its first meeting in Pinehurst in September 1965 and explored a great amount of material and some tentative outline of directions in developing a set of guidelines to direct the profession in respect to developing a mechanism related to utilization review. The Chairman, along with others of the Committee, attended a special conference conducted by the AMA in Philadelphia in late November, 1965 and there gained other experiences and suggestions from many medical leaders who had given much study to the problem of utilization.

The Committee met again in January 1966 and debated for several hours the most useful material

and ideas which it had gathered and at said meeting developed a set of guidelines which it concluded to recommend to the Executive Council for consideration and adoption as recommended guidelines for stimulating local medical staff and county society action in the promotion of local utilization mechanisms. Therefore, the Committee presented this material to the Executive Council on January 30, 1966 and the report and recommendations of the Committee were approved by the Executive Council with the direction that the guidelines be reproduced by the N. C. State Board of Health for dissemination to all general hospital medical staffs and to all hospital administrators. The adopted report and recommendations with three related appendices here follow:

UTILIZATION REVIEW

With the passage of the Medicare Act—Public Law 89-97—the activation and implementation of the Utilization Review Program became the law of the land. In order to qualify each hospital or facility must apply to the North Carolina State Board of Health for certification as a Provider of Service under P. L. 89-97. In order to be certified each facility must submit in writing a plan for Utilization Review of medical services rendered.

P. L. 89-97 (Medicare) indicates that the Utilization Review Plan must have two mechanisms:

Medical Necessity Determination

1. Review of the medical necessity for inpatient services during a continuous period of extended duration. This review must be done as of such days as specified by regulations. This could be called *Medical Necessity Determination*. All patients hospitalized continuously for 30 days or longer will automatically be reviewed at the end of the 30 day period, and thereafter at 15 day intervals, by the Utilization Review Committee.

Utilization Evaluation

2. The second mechanism serves for retrospective review of admissions, duration of stay, and professional services furnished (including drugs and biologicals) with regard to their medical necessity and the efficient use of facilities and services—*Utilization Evaluation*.

Exhibit I (attached) is submitted as a possible guide in developing Utilization Review Forms. Each individual hospital or facility will devise its own mechanism for review on a sampling basis or in depth as indicated by the requirements of that institution. All cases admitted to a facility are subject to review by the Utilization Review Committee. Each facility shall determine its own sampling procedures. These plans must meet the approval of the North Carolina State Board of Health as the officially designated agency for certification

of Providers of Service under P. L. 89-97.

Under Utilization

The Utilization Review Committee should be alerted to look for *under utilization* as well as *over utilization*.

Local Utilization Review Committees

The Local Utilization Review Committees shall consist of 2 or more members as required by the law. Membership should include the chiefs of each major department or a representative designated by the chief.

Full time staff physicians from the department of radiology, pathology, and anesthesiology should be represented.

A member of the hospital administration should attend the meetings without voting privileges. He should be responsible for the minutes of the meeting and for furnishing information on administrative procedures and policies which the committee may request.

The medical records librarian, the operating room supervisor, or any hospital department head may be asked to sit in on the meetings.

It is recommended that members of the committee serve two or more years and new appointments be staggered so that experienced members at all times be on the committee.

The committee should meet *one or more times each month*. Review of cases and records may be done by the committee members prior to the meeting.

The committee has no disciplinary powers. The committee reports its findings and recommendations to the medical staff for its action.

H. Fleming Fuller, M.D., Chairman

(See Exhibit I, a possible utilization Review form, on page 57, at end of reports.)

REPORT OF THE DELEGATES TO THE AMA

During the past year, there has been much activity on the national scene of medicine which has resulted in very active meetings of the House of Delegates. There were three such meetings—one called in October in addition to the regular meetings in June and November.

The following gives the activities of the June, October, and November meetings:

The American Medical Association's 114th Annual Convention was held in New York, June 20-24, 1965. Dr. James Z. Appel, Lancaster, Pennsylvania, was installed as President for the coming year. Dr. Charles L. Hudson of Cleveland, Ohio, a member of the AMA Board of Trustees since 1961, was named President-Elect.

The 1965 AMA Distinguished Service Award was won by Dr. Tinsley R. Harrison of Birming-

ham, Alabama, for his outstanding work in the field of cardiovascular diseases. In general, this was a most successful convention. Out of a total of 64,517 registrants attending this convention, 24,268 were physicians.

During the four day session, there were many controversial issues discussed, the most important one being health care legislation and the suggested activities and actions of the House of Delegates.

There were 10 resolutions and portions of the inaugural address directed to this area. After much discussion, the following resolution was adopted:

"The physicians of the United States of America pledge themselves to continue their search and activity, in whatever social environment may develop, to secure or to restore the freedom, high quality and availability of medical care which has been traditional in our country.

"When the fate of the pending medicare legislation is determined, this House will review, in special session if necessary, the effect of the law and take whatever action is deemed necessary..

"In keeping with the testimony before your Committee, and the expressed policies of this House, this action should in no way be interpreted as a change in Section 6 of the 'Principles of Ethics' of the American Medical Association which plainly states: 'A physician should not dispose of his services under terms or conditions which tend to interfere with or impair the free and complete exercise of his medical judgment and skill or tend to cause a deterioration of the quality of medical care'; and that this House of Delegates reaffirm the principles of the Bauer amendment adopted in 1961.

"The House of Delegates reaffirm the nine principles for standards of health care programs as adopted by the House of Delegates in its special meeting February 7, 1965, and amended to read as follows:

- '(1) No person needing health care shall be denied such care because of the inability to pay for it.
- '(2) It is appropriate that government revenues be used to finance health care when other resources have been found to be inadequate.
- '(3) Every level of government, municipal, county, state and federal, should assume a responsible share in the financing of such programs.
- '(4) The health care provided by such programs should be adequate and should be equal to that available to those who can afford to pay.
- '(5) Maximum use should be made of voluntary prepayment and insurance mechanisms.
- '(6) Administration of such program should be the responsibility of the state government. Participating states should be required to meet adequate standards of administration in order to qualify for federal funds.
- '(7) Eligibility requirements for benefits should be fair, realistic, uncomplicated and practical.

'(8) Any such health care programs should provide funds only, and not direct services.

'(9) Funds for such programs may come from general tax revenues and not from social security taxes.'"

As an outcome of this and other actions referable to legislation, the House adopted another resolution which included the following statement:

"This House of Delegates restate its offer to meet with the President of the United States through our Legislative Task Force to discuss proposed medical care legislation with a view to safeguarding the continued provision of the highest quality and availability of medical care to the people of the United States.

"The House of Delegates of the American Medical Association instruct the Board of Trustees of the American Medical Association to embark immediately on active campaign to inform the membership of the American Medical Association of the grave considerations in adhering to our principles of ethics posed by legislation now pending before Congress.

"The American Medical Association strongly urge those branches of the government interested in the formulation, the enactment, and the implementation of laws which deal with the provision of professional medical services to the public to seek and utilize the advice and assistance of the physicians who will render such services. Such advice and assistance should be received through our chosen representatives, the officers of the American Medical Association.

"The American Medical Association intensify its efforts to modify all such pertinent legislation, employing the necessary means and appropriate actions to the end that the health of the public and the pursuit of excellence in medicine be unimpaired by such legislation.

"The American Medical Association make every effort to continue, and where necessary, to expand its communication activities so that all physicians as members of component medical societies will be promptly, continuously and completely informed of developments in this critical area during the coming months."

There was much discussion in regard to the DeBakey Commission Report and after reviewing 7 resolutions, the following policy was adopted by the House:

"The American Medical Association point with pride to the immense strides made in the approaches to the conquest of heart disease, cancer, and stroke under existing patterns of research and medical practice; strongly favoring the use of available financial support for extension of these patterns rather than replacement by a complex of medical control centers and satellites.

"The American Medical Association oppose those particular Commission recommendations which call for and have stimulated proposals for hastily con-

trived and unproven sweeping changes in the pattern of medical research, education, and patient care.

"The component state medical associations be urged to conduct conferences with medical educators and scientists, medical staffs of hospitals, medical society representatives, and other interested parties, for the purpose of exchanging information and for the development of such recommendations as may be appropriate for the continued improvement of medical education, research and patient care.

"The state medical associations be urged to report findings and recommendations resulting from these conferences to the AMA Board of Trustees, for the information of the Board, its councils, and the Association members."

In 1963, The Gundersen Committee was appointed to review the size, make-up, and function of the House of Delegates. The preliminary report from this committee was received. Action is to be taken at the December meeting in Philadelphia because of some points of the report being unfinished.

In miscellaneous action taken on 73 separate resolutions and many reports from councils, committees, Board of Trustees, and the House of Delegates, the highlights are included:

1. Urged medical schools and agencies concerned with continuing education to incorporate "appropriate learning experiences" for physicians in counseling relating to sexual attitudes and behavior.

2. Recommended that component medical societies be urged to encourage the establishment of cancer registries in the local hospital but this was not made a requirement for accreditation by the Joint Commission on the Accreditation of Hospitals.

3. Instructed the Council on Medical Service to remain alert to Veterans Administration policies and provisions on treatment of veterans by private physicians, especially referable to prescriptions. Advised meeting with pharmacies in this area.

4. Reaffirm policy concerning the practice of radiology, pathology, anesthesiology, and physical medicine in hospitals.

5. Reaffirm the policy that human blood, as living tissue, should not be purchased under insurance contracts.

6. Urge state and local societies to encourage development of Explorer Scout Program for Medical Specialty Posts.

7. Adopted a resolution calling for a continued effort to secure the passage of legislation which will remove tax discrimination against professional people.

8. Directed the Board to review the subject of federal assistance for operating expenses for health and medical education facilities.

9. Directed the Board to study opportunities and problems associated with operation Head Start and other programs now operating under the Economic Opportunity Act.

10. Referred to the Council on Medical Education the resolution for approval of American Board of Family Practice.

11. Urge the Council on Medical Education to establish a standard date of appointment for all approved residency training programs.

12. Encourage state and county medical societies in the formation of state Association of Professions.

13. The Resolution introduced by the North Carolina Delegation for the formation of long-term planning and projects was referred to the Board of Trustees.

In addition to the election of Dr. Hudson, the following additional offices were filled at this meeting:

Dr. Irvin E. Hendryson elected to the Board of Trustees; Dr. W. Andrew Bunten, Cheyenne, Wyoming, elected to Association's Vice Presidency; Dr. Milford O. Rouse and Dr. Walter C. Bornemeier were re-elected Speaker and Vice Speaker respectively of the House of Delegates; Dr. Bland W. Cannon was elected to the Council on Medical Education; to the Council on Medical Service. Dr. C. A. Hoffman of West Virginia and Dr. Russell B. Roth of Erie, Pennsylvania were re-elected; Dr. George D. Johnson of Spartanburg, South Carolina was re-elected to the Council on Constitution and By-laws.

A Special Session of the AMA House of Delegates was held in Chicago on October 2-3, 1965. This entire agenda was referable to the legislative activities and action of Public Law 89-97.

The House became a committee as a whole and heard reports by legal counsel in reference to non-participation by individual physicians. He likewise advised that this technique could not be sponsored by groups, such as the AMA House of Delegates or any other organization, as it would be breaking the anti-trust law. Many alternate proposals were made by the various segments of the House and members of the AMA who were visitors to the meeting. All were thought to be illegal according to legal counsel. Over 125 witnesses testified and recommended actions of various types. After heaving these recommendations, the committee developed several policy statements.

1. "Legal counsel for the American Medical Association has stated that an individual physician acting independently and not in concert with others can lawfully refuse to accept any person as a patient who is a beneficiary under the program, or he may elect to treat such persons."

2. "The American Medical Association opposes any program of dictation, interference, or coercion, whether direct or indirect, affecting the freedom of choice of the physician to determine for himself the extent and manner of participation or financial arrangement under which he shall provide medical care to patients under Public Law 89-97."

3. Reiteration of the Bauer Amendment as

adopted in 1961 and the 9 principles for standard of health care adopted in 1965.

BAUER AMENDMENT

ADOPTED—A-61

The House of Delegates of the American Medical Association records its opposition to any legislation of the King-Anderson type. Its opposition is based on the facts that such legislation does not meet the needs of the situation; interferes with the doctor-patient relationship; interferes with the rights of doctors employed in hospitals; is inordinately expensive; leads inevitably to further encroachments by government into medical care; results eventually in a deterioration of the type of medical care rendered the public; and is therefore detrimental to the public interest.

The House of Delegates invites attention to the fact that the medical profession is the only group which can render medical care under any system and that the medical profession is best qualified to determine how the best medical care can be delivered.

The House of Delegates believes that the medical profession will see to it that every person receives the best available medical care regardless of his ability to pay; and it further believes that the profession will render that care according to the system it believes is in the public interest; and that it will not be a willing party to implementing any system which we believe to be detrimental to the public welfare.

NINE PRINCIPLES FOR STANDARDS OF HEALTH CARE PROGRAMS

ADOPTED—S-65

- (1) No person needing health care shall be denied such care because of the inability to pay for it.
- (2) It is appropriate that government revenues be used to finance health care when other resources have been found to be inadequate.
- (3) Every level of government, municipal, county, state and federal, should assume a responsible share in the financing of such programs.
- (4) The health care provided by such programs should be adequate and should be equal to that available to those who can afford to pay.
- (5) Maximum use should be made of voluntary prepayment and insurance mechanisms.
- (6) Administration of such program should be the responsibility of the state government. Participating states should be required to meet adequate standards of administration in order to qualify for federal funds.
- (7) Eligibility requirements for benefits should be fair, realistic, uncomplicated and practical.
- (8) Any such health care programs should provide funds only, and not direct services.
- (9) Funds for such programs may come from general tax revenues and not from social security taxes.

The House also adopted resolutions involving regulations of Public Law 89-97 as outlined.

(a) "The American Medical Association shall continue to meet with representatives of agencies and departments of the Federal Government, to participate in such advisory committees which are created, and to contribute whatever advice and suggestions are deemed advisable and necessary in the formulation and revision of regulations which will help it achieve Medicine's objectives on behalf of the public and the profession."

(b) "The American Medical Association urges every physician, regardless of the extent of his involvement, to render whatever advice and assistance he can so that regulatory changes and/or legislative modifications may be suggested or sponsored by the American Medical Association in order that the best interests of the public and the profession may be protected in the provision of medical care."

(c) "This House of Delegates expresses confidence in the Board of Trustees of the American Medical Association, its Advisory Committee, and the three-man Consultant Committee on Public Law 89-97 for their continuing efforts to secure regulations which are in the best interests of good patient care."

The Board of Trustees added Dr. Donovan Ward to the Advisory Committee and appointed three consultants to the Public Law Committee; namely, Dr. Amos Johnson of North Carolina, Dr. Edward Annis, Miami, Florida, and Dr. William O. LaMotte, Wilmington, Delaware.

Thereafter miscellaneous actions were taken on such items as

1. certification of the physicians,
2. recommendations for insurance intermediaries were left to the appropriate state and the local medical society for expression of their selection of a carrier,
3. reasonable fees were discussed and suggestions adopted that disputes over the fees should be resolved with the appropriate local medical society participation,
4. Utilization Review Committee should be composed of practicing physicians,
5. full explanation of compensation for services should be rendered to the physician to enable him to decide whether he wants to receive a compensation from federal agency or bill the patient directly,
6. the complete legal opinion by the AMA counsel was made available to those desirous at their expense for copies,
7. separation of professional fees from hospital charges were recommended and regulations involving same were to be promulgated,
8. recommendations of the current reports from the Advisory Committee be given to the House of Delegates and the state associations so this information could be disseminated to the various local societies and members thereof. Other means of communication, including the AMA News, AMA Journals, and publications, should be used to the

fullest extent to keep the membership informed of activities.

9. The Resolution referable to a long-range planning committee was referred to the Trustees for action.

Thus, a very healthy period of discussion, testimony, and reports on legal potentialities were given to the delegates and action was taken accordingly. Policies were set up to function in this light.

The third meeting of the House of Delegates during 1965 occurred on November 28 through December 1 in Philadelphia, Pennsylvania. The following subjects contributed most to the meeting and the actions which followed at this meeting.

"Usual and customary" fees and prevailing fees, abortion and sterilization, billing and payment for medical services, membership dues, organization of the House of Delegates, and federal health care laws were among the major subjects acted upon by the House of Delegates at the American Medical Association's 19th Clinical Convention held Nov. 28- Dec. 1 in Philadelphia.

The House elected Dr. Drew M. Peterson of Ogden, Utah, to fill an unexpired term on the Council on Medical Service.

"Usual and Customary" and Prevailing Fees

One of the most controversial issues before the House and the Reference Committee on Insurance and Medical Service was the "usual and customary" fee concept and the prevailing fees program of the National Association of Blue Shield Plans.

The House reaffirmed its support of the "usual and customary" fee concept as the basis for reimbursing physician participants in government programs at all levels of government. It also urged "the individual physician's usual and customary fee concept to all third parties."

It took this action after modifying a Board of Trustees' report on the new "prevailing fees" program of NABSP. The modified report recommended:

"That the concept of the prevailing fees program of the NABSP be noted as one of the methods of compensation in those regions where the prevailing fees program is approved by the local or state medical society."

In its report, the Board recalled a statement adopted by the House at the 1965 Annual Convention, which recommended that when government assumes financial responsibility for an individual's health care, reimbursement for professional services should be on the same basis as in the case of other indispensable elements of health care.

"Therefore, reimbursement for the services of physicians participating in government-supported programs should be on the basis of 'usual and customary' fees," the statement said.

Abortion and Sterilization

Recommendations for the enactment of legislation to legalize abortion and sterilization under certain conditions were referred to the Board for

further study. This action was taken after the House had received a report from the Board containing the recommendations of the Committee on Human Reproduction.

The House concurred in the reference committee's report that "it is not appropriate at this time for the AMA to recommend the enactment of legislation in this matter (abortion) for all states. The problem is essentially one for resolution by each state through action of its own legislature."

It also endorsed a statement that "appropriate legislation be enacted, wherever necessary, so that all physicians may legally give contraceptive information to their patients, consistent with the policy statement of December, 1964, and with the judgment and conscience of each individual physician."

Billing and Payment for Medical Services

Eight statements on fees charged by physicians for medical services were affirmed by the House. These are applicable "irrespective of whether such fees are paid by the patient, or paid or reimbursed in whole or in part under Public Law 89-97, or any other third party plan," the House stated. Here are the eight statements:

"1. The intimate relationship between physician and patient is served best without the interposition of any third party carrier, whether in the area of diagnosis and treatment or the payment for these services.

"2. It is the patient's responsibility to deal with third party carriers in the area of financial assistance provided that the physician is at all times mindful of his obligations to the patient under Section 1 of the Principles of Medical Ethics.

"3. The physician-patient relationship is served best when there is an advance understanding regarding the payment of fees and the physician bills the patient directly for services rendered. However, the physician is ethically free to choose in each case the manner in which he is to be compensated, based upon the exercise of his independent judgment.

"4. The American Medical Association does not approve of any program which may directly or indirectly promote the charging of excessive fees or which interferes with the physician's right to charge fees commensurate with the services he renders.

"5. The American Medical Association opposes any program of dictation, interference, or coercion, whether direct or indirect, affecting the freedom of choice of the physician to determine for himself the extent and manner of participation or financial arrangement under which he shall provide medical care to patients under Public Law 89-97, or other third-party plans.

"6. It should be remembered that insurance does not create any new wealth. It merely assists in conservation. Insurance may conserve the ability of an insured person to fulfill his normal financial

obligations. It does not enhance his ability to discharge added responsibilities if they are in the form of increased fees. To use insurance as an excuse to revise professional fees upward is but to contribute to the defeat of its purpose. If these indisputable and self-evident facts are not embraced by the entire membership of the profession, then it will have dealt irreparable harm to the whole movement. Also, any such failure might give impetus to whatever demand now exists for forcing rigid benefit schedules on the professional. (The foregoing is from a report of the Council on Medical Services to the House of Delegates at the Clinical Meeting in 1954).

"7. The charging of an excessive fee is unethical and is contrary to Section 7 of the Principles of Medical Ethics. The physician's fee should be commensurate with the services rendered and the patient's ability to pay. (The foregoing is from a report of the Judicial Council which was approved by the House of Delegates at the Clinical Meeting in 1960.)

"8. It is not contrary to conscience for the physician to consider the patient's ability to pay if he fixes his particular fee within reasonable limits. In matters relating to fees, the physician should try, to the best of his ability, to insure justice to the patient and himself and respect for his profession. (The foregoing is from an opinion of the Judicial Council in 1958.)."

Membership Dues

A \$25-a-year increase in membership dues, effective Jan. 1, 1967, was endorsed by the House when it was informed by the Board that additional income will be needed by then to avoid deficit spending.

The increase, to \$70 a year for the AMA's 165,000 dues-paying members, will go before the House for final action at the 1966 Annual Convention because AMA Bylaws state that annual dues may be prescribed by the House only for the ensuing calendar year.

Board Chairman Percy E. Hopkins, M.D., told the House that "during 1964 and 1965, the AMA will have incurred an operating deficit of more than 1 million dollars." The budget for 1966, he said, is now narrowly in balance.

The 1966 budget calls for spending some 27.6 million dollars, Dr. Hopkins reported, including almost 10½ million dollars on scientific programs, 5 million on health education and other medical service programs, more than 1 million to maintain physician records, and another million in the communication's program. Travel and meeting costs will exceed 2 million dollars.

"In a society," Dr. Hopkins said, "which has adopted inflation as a national policy and in which our system of medical care has become a pawn of politicians, it is not realistic to expect that we can limit tomorrow's programs to yesterday's income. Already demands are mounting from medical socie-

ties and physicians for a stronger and more effective AMA. These needs must be met and they must be adequately financed."

Federal Health Care Laws

The House took a number of actions with regard to federal health care laws passed in 1965, such as PL 89-97 (Medicare) and PL 89-239 (the Heart Disease, Cancer and Stroke Amendments). These actions included:

—"That the AMA immediately seek remedial action to delete the requirement in Public Law 89-97 that a patient be hospitalized to establish eligibility for nursing home care."

—"That the AMA immediately seek remedial action to amend Public Law 89-97, Part B, Title XVIII, by deleting the word 'receipted', from Section 1842 - Part 3, Item B, line (ii), and substituting 'such payment will be made on the basis of a method of payment so arranged to preserve and continue the profession's current practice of billing.'" Also approved "that the AMA recommend that the Department of Health, Education and Welfare establish that an agreement for payment between the patient and physician constitutes valid evidence of services rendered."

—Endorsed the Council on Medical Services' recommendation "that the state and local medical societies be urged at this time to assume leadership in the establishment of local advisory committees" under the Heart Disease, Cancer, and Stroke Amendments of 1965. The House noted that a National Advisory Council under PL 89-239 already has been appointed by federal officials and that the AMA was not given an opportunity to recommend possible appointees to the Council. "Therefore," the House declared, "active physician participation at the state and local levels is of utmost importance."

—Declared that the AMA Advisory Committee on PL 89-97 and 89-239 should persist in its efforts to achieve "practical recognition" by HEW of the differences between utilization review and claims review. The House adopted a report of the Council on Medical Service which said that "widespread confusion exists between the utilization review function and the claims review function." It also adopted a series of recommendations in the report aimed at clearing the confusion.

Other Important Actions

A study committee established by the Board of Trustees to evaluate planning techniques and development was approved by the House. The committee was given the tasks of (1) reviewing and studying current planning procedures in AMA, and (2) studying and recommending new mechanisms for organizational arrangements to achieve more effective planning and development in the future. Membership on the committee includes five Board members, the chairmen of the Councils on Medical Service, Medical Education, and Legislative Activities, the Speaker of the House, and two

House members selected by the Speaker.

The House repeated a previous policy statement urging the creation of a separate post in the Cabinet of the President of the U. S. for a Secretary of Health.

Contributions totaling more than \$463,000 were presented to the American Medical Association Education and Research Foundation.

These were: \$203,655 from the California Medical Association, \$189,000 from the Illinois State Medical Society, \$45,000 from the New Mexico State Society, \$15,610 from the Utah State Medical Association, \$9,605 from the Medical and Chirurgical Faculty of Maryland, and \$510 from the Woman's Auxiliary to the Clackamas County, Ore., Medical Society.

REPORT TO THE HOUSE OF DELEGATES
MEDICAL SOCIETY
OF THE STATE OF NORTH CAROLINA
From

Hospital Saving Association, Inc.
Chapel Hill, N. C.

1965 was another year of substantial growth and sound fiscal operation for Hospital Saving Association. This is evidenced by the comparison of 1964-1965 operations attached.

For many years, Blue Cross and Blue Shield has provided coverage for its subscribers without regard to age and has sought to provide realistic coverage on the most economical basis consistent with good medical care. We believe, and still believe, that aid through tax funds should be provided on the basis of need. Despite the efforts of the majority of those in medical practice and the efforts of the prepayment plans they sponsor, Public Law 89-97, Medicare, was passed by the Congress in 1965.

Only time can tell the effects of this on Blue Cross and Blue Shield. The American Medical Association took the position that it would continue to try to effect changes in Medicare but would, in the meantime, exercise opportunities to give the Program professional direction to the end that there would be as little disruption as possible in the country's hospitals and doctors' offices. In line with this philosophy, the Medical Society of the State of North Carolina endorsed and sponsored the Blue Shield Plan to be the intermediary Carrier for Part B of Medicare. This request went unheeded and a commercial insurance company was named as Carrier for North Carolina. The Part "A" hospital and ursing home benefits of Midicare will be administered in North Carolina by Blue Cross.

The Association's membership certificates exclude benefits when care is provided at tax-payer expense and the Association will not attempt to duplicate benefits of Medicare. However, the Association will offer its over-age 65 subscribers and other North

Carolinians eligible for Medicare benefits, a supplementary coverage so that they may have the opportunity to prepay coverage for some of the gaps in Medicare and to provide benefits for some services which are not provided by Medicare. A choice between a basic supplement and a more comprehensive extended coverage will be offered. Full details will be made available to the public and to the doctors in North Carolina.

The continuous process of upgrading the level of benefits for professional service was carried on at a good pace in 1965. Extended coverage to provide benefits for outpatient diagnostic x-rays, pathology, and physical therapy, is now held by 50% of the Association's subscribers. Sale of Inpatient Medical Endorsements providing professional benefits for non-surgical admissions increased more rapidly than any other segment and 48% of subscribers now have such coverage. Increasing the extent and quality of such coverage is a major objective of the Association.

The Association's Officers and particularly the Board Members, elected by the State Medical Society, and I take this opportunity to express sincere appreciation to Dr. George Paschal, President, and Mr. James T. Barnes, Executive Director, who have followed economic developments affecting Plan operation closely and given generously of their time and support.

The nine-physician-member Blue Shield Committee of the State Medical Society continued to occupy a key role in providing professional guidance and medical determination. The Chairman of this committee changed hands due to the regrettable illness of Dr. W. Z. Bradford. The Association is particularly appreciative of Dr. Max Rogers' acceptance of the Chairmanship and commends him most highly for the great amount of time and effort that he has devoted to this task. The Blue Shield Committee's activities have been particularly important during 1965 due to Medicare Legislation and the development of a new concept in scheduling allowances for professional services. I refer to the Prevailing Fee Concept which offers opportunity to pay most physicians their usual charge for medical services. This should also resolve past difficulties of fixed fee schedules in providing appropriate allowances for professional services. Rather than having a "Plan A" which becomes outdated and is succeeded by "Plan B", etc., the Prevailing Fee Concept offers the opportunity to have benefits which will adapt themselves to factors of inflation, changes in customary charging practices, and the development of new procedures and techniques in medicine. It will offer a slightly more complicated rate structure for the Association; however, the Association welcomes it as a means whereby the needs of the public and the desires of industry can be met in accordance with prevailing practice-charging patterns at the local level.

	1964	1965
Total Assets	\$15,172,075	\$17,193,894
Legal and Operating Reserves	7,472,513	8,527,921
Total Fee Income		
(Regular Subscribers)	26,248,666	29,657,100
Total Claim Payments		
(Regular Subscribers)	24,257,075	26,965,186
Operating Expenses—% of		
Fee Income	7.80%	7.31%
Total Claims Paid—All Programs		
Administered by HSA (Includes		
Military Dependents and FEP)	28,459,810	31,475,920
Blue Shield Participants	721,907*	733,077
Blue Shield Claims Paid—		
Number	187,200	201,701
Amount	5,843,296	6,296,043
Blue Cross Participants	726,160*	735,625
Number Inpatient Admissions	109,943	112,192
Amount Paid Inpatient Cases	18,722,575	20,707,365
Days Paid	748,039	770,777
Average Stay	6.80	6.87
Average Payment Per Case	170.29	184.57
Admissions Per 1,000 Per Year	152	152
National Blue Cross Per		
1,000 Per Year	148	148
*Includes Subscriber Participants in		
Administered Accounts Numbering	76,206	74,408
E. McG Hedgpeth, M. D.		

HOSPITAL CARE ASSOCIATION DURHAM, NORTH CAROLINA

We are pleased to report that 1965 was another year of progress for the Hospital Care Association. In both its Blue Cross Plan for hospital service and its Blue Shield Plan for medical service, the Association registered substantial gains in new enrollment, benefit payments, and all other areas of its operations.

For its combined Blue Cross and Blue Shield operations, the Association had a net gain of 16,729 persons. The increase in enrollment raised total membership over the 500,000 mark at year's end. Benefit payments amounted to \$19,025,324, a net gain of \$2,430,119 over 1964 payments.

1965 marked the 32nd consecutive year that Hospital Care Association has shown an increase in enrollment and benefit payments. The oldest hospital and medical service plan in the state, the Association has grown each year since it was established in 1933.

A summary of the Association's major activities in 1965 follows:

Benefits

Benefit payments increased by 15 per cent.

At the end of 1965, payments to hospitals and physicians averaged approximately \$1,585,444 per month.

Rising hospital costs, enrollment growth, and increased utilization were mainly responsible for the Association's ever-increasing benefit payments. As hospital charges continued upward, Blue Cross benefits were increased to meet them. To a lesser extent this was also true of increases in Blue Shield allowances, as recommended by the Blue Shield Committee of the MSSNC, to meet higher surgical and medical costs.

The staff of the benefits department was increased to meet the ever-increasing demands for service. Prompt handling of claims was stressed. Most hospital and physicians' vouchers were approved for payment the same day they were re-

ceived in the Association's home office in Durham.

Workshops, designed to facilitate the prompt and efficient processing of claims, were conducted by the Benefits Department for hospital personnel in Raleigh, Greenville, Wilmington, Winston-Salem, Charlotte, and Asheville. Similar conferences for physicians' secretaries are planned in 1966.

Enrollment

The Hospital Care enrollment gain of 3.5 per cent was about evenly divided between group and nongroup enrollment. In group enrollment, some 224 new employee-groups were established. National Spinning Company, a major textile operation with three plants in North Carolina and more than 1,000 employees, was the largest new group enrolled during the year.

In nongroup enrollment, the annual "Easy-Joining Days" open enrollment was conducted in April. More than 6,000 new members were added during this special campaign.

Rural enrollment through 62 county Farm Bureau groups was increased by 3,639 members. A special enrollment was conducted to promote the sale of a Student Certificate to college and trade school students.

Upgrading of benefits on both existing contracts and new sales continued in both the group and nongroup departments. Many room allowances and surgical schedules were increased; and endorsements covering Extended Benefits, inhospital medical care, cancer and dread disease, oral surgery, and outpatient care in physicians' offices were sold to thousands of new and old subscribers.

A new branch office was opened in Hickory to serve eight counties in the northwestern section of the State.

Blue Shield Developments

The conversion of existing memberships to the Doctors' Program of the MSSNC continued. The number of persons enrolled on Doctors' Program contracts increased by 29 per cent during the year.

The number of physicians participating in Hospital Care Association's Blue Shield program increased to 61 per cent. Participating Physicians agreements had been signed by 2170 of the 3575 physicians in active practice in the state as of December 31.

The Hospital and Physicians Relations Department was expanded to meet the increasing demands of Blue Cross and Blue Shield programs. An additional full-time representative was hired to work with two other representatives previously employed in a full-time program of visiting hospitals and physicians to discuss Blue Cross and Blue Shield problems and procedures, including education of claims personnel and general audits of records relative to claims.

The Blue Shield Newsletter, designed to keep HCA Participating Physicians and their office assistants informed about significant new Blue Shield developments, was published bimonthly. The Newsletter was disseminated to all physicians in

North Carolina.

Administration and Planning

Increased utilization of electronic data processing equipment resulted in further economies in administrative overhead. This modern computer will enable the Association to handle expanding work schedules without additional personnel as enrollment and claims volume increases.

A house and lot adjoining the home office property in Durham were acquired for possible future expansion.

Public Relations and Advertising

A comprehensive, year-round educational and advertising program was conducted by the Public Relations Department. Of special interest to the medical profession was a new series of locally-produced documentary films on major developments in the health care field in North Carolina. Two of these programs—"Hospital Costs" and "The Crisis in the Emergency Room"—were shown in prime time on five TV stations over the State. The President of the State Medical Society appeared on both of these documentaries. The films have since been shown to numerous civic clubs throughout the State and their use in this manner is being continued.

A large exhibit depicting the reasons for the rising costs of health care was shown continuously during the year in hospitals throughout the State. It is booked ahead at three-week intervals through the summer of 1966.

Newspaper and magazine advertising and publicity was carried out year-round in daily and weekly papers and state magazines.

Staff personnel made many talks to civic clubs and other groups on rising hospital and medical costs. More than 50,000 copies of a brochure on this subject were produced and disseminated to the public through hospitals and doctors' offices. The Public Relations Director completed a second term as Chairman of the North Carolina Committee on Nursing and Patient Care, a statewide group representing the major health disciplines and the public, dedicated to general improvement of patient care. A hospital visitation study and several other projects important to the medical profession were initiated by the Committee during the year.

Financial Condition

The financial condition of the Association remained sound. As of December 31, 1965, assets were \$11,774,983, with liabilities of \$5,467,837 and a reserve of \$6,307,146. The reserve fund is equal to 3.63 months of average operating expense, which is sufficient to meet the requirements of the national Blue Cross and Blue Shield approval programs and the North Carolina Department of Insurance.

Nongroup Rate Increase

A general rate increase, necessitated by steadily rising hospital costs, was put into effect on all nongroup certificates beginning January 1. The in-

crease, which averaged 24.5 per cent, was approved by the State Insurance Commission after a public hearing which showed that the Association had been losing money on its nongroup business for some time. The rate increase enabled the nongroup department to operate on a self-supporting basis in 1965.

Utilization Program

In an effort to minimize increases of Blue Cross and Blue Shield dues in the future, a program to control unnecessary usage of benefits was expanded. Physicians, hospitals, government, health agencies, the public and Blue Cross and Blue Shield Plans are working together in the program in a concerted effort to stabilize Blue Cross and Blue Shield dues by controlling unnecessary utilization.

It is too early to forecast with any assurance of accuracy the results of this program. However, the potential saving to Hospital Care Association and its subscribers is enormous. Already the ability to demonstrate that it has a positive program aimed at controlling costs and utilization is proving of value to the Association in its sales program. This assurance of cost control is helping to hold groups and individual subscribers who might otherwise be lost. It is also helpful in new enrollment situations where sophisticated employers are increasingly cost conscious.

Should the Association be able to effect a reduction of even half a day in the average length of stay, as a result of this program, the overall estimated annual saving would exceed \$1 million. Also, if the admission rate to the hospital can be reduced from the present 150 admissions per 1,000 members, substantial savings can be realized.

As we pointed out last year when this program was begun, the physician is the key man in any utilization program since only he can admit or discharge a patient from a hospital. As your duly elected representatives to the Hospital Care Board of Directors, we again urge the careful attention of all members of the Medical Society to this important new program. With your help, much can be accomplished; without your help, little will come of it.

Government Relations

In the area of government relations, the enactment of the Medicare bill to provide health care for the aged under Social Security was an unprecedented development. The Blue Cross and Blue Shield Plans in North Carolina were formally nominated by the hospitals and physicians of the state to serve as administrative intermediaries for the vast program which will go into effect July 1, 1966.

Hospital Care Association, like other Blue Cross and Blue Shield Plans, expects to lose some of its estimated 30,000 members above 65 when Medicare begins. However, a new supplementary coverage program, designed to fill the gaps in Medicare, is being developed. All present members over 65 will be given an opportunity to convert to this new plan

without answering health questions. We believe that many persons over 65, both those now enrolled and those not enrolled, will want to avail themselves of this supplementary protection.

Of course, all of our programs for people under 65 will be continued and in many cases strengthened as necessary to make them more adequate to meet the rising costs of hospital and medical care. Hospital Care Association expects to weather the storm and to show continued progress in 1966, Medicare notwithstanding.

The confidence, cooperation, and encouragement of its participating physicians contributed importantly to the progress Hospital Care Association made in 1965. The Association expresses its gratitude for this continuing support.

J. Street Brewer, M. D., Chairman

C. T. Wilkinson, M. D.

W. C. Goley, M. D.

A. T. Hamilton, M. D.

Directors representing the Medical Society of the State of North Carolina.

NORTH CAROLINA MEDICAL CARE COMMISSION

Report of the Activities of the North Carolina Medical Care Commission for the year ended December 31, 1965.

Submitted by Physician Members of The North Carolina Medical Care Commission Representing the Medical Society of the State of North Carolina.
Construction of Hospitals and Medical Facilities

There is presently under contract or in planning some 40 projects involving total costs of some \$80 million. This is the largest construction program ever undertaken by the Medical Care Commission during its 20-year history. During the year, there were 10 hospital projects approved which will provide the State, when completed, with 700 additional general hospital beds. There were authorized two new county public health centers and 322 new nursing home beds. Under newly authorized Public Law 88-164, the Commission approved 2 mental health center projects and 1 facility for the mentally retarded. Several others are in planning. The total cost of all health facilities approved during the current year amounts to \$31 million, of which the State supplied 2 per cent, the local communities 56 per cent and the Federal Government 42 per cent. The total number of projects approved in North Carolina under the Federal program exceeds that of any of the other states.

Licensure of Hospitals

The State's 170 hospitals, through the hospital licensing program, have been continually upgraded by constant inspections to insure acceptable services and safety. North Carolina is among the highest ranking states in the number of hospitals accredited by the Joint Commission on Accreditation of Hospitals irrespective of wealth or population. As of

December 31, 1964, 70 per cent of licensed hospitals eligible for accreditation were accredited by the JCAH, representing 84 per cent of the beds in the State. It is expected that a number of hospitals accredited for the first time in 1965, when announced by the Joint Commission, will improve even further this standing.

Scholarships for Medical and Related Studies

During the year, the Commission awarded a total of 100 scholarships financed with State appropriations to students in medicine, dentistry, pharmacy, nursing, medical technology and other health related studies. This is the largest number of students approved in any one year during the history of the medical loan program. These applications, including funds earmarked to continue the students approved during the year through graduation, involved funds of \$300,000.

During the year, the Commission made important changes in the loan program, especially as it applies to students of medicine. Previously, the grants were in the form of loans and the recipient repaid the funds borrowed with interest in addition to practicing under specified conditions. Now a physician graduating under the program, after he has practiced in a rural community, is forgiven his loan entirely on the basis of a calendar year's practice for each academic year a loan is received. If the recipient elects to pursue other types of practice, then his notes provide for the repayment of the loan in full with interest at 6 per cent.

J. Street Brewer, M. D.

Powell G. Fox, M. D.

Harry L. Johnson, M. D.

COMMITTEE ON VENEREAL DISEASE

The Committee on Venereal Disease endorses the policy of the USPHS in stepping up the attack on venereal diseases. The number of primary and secondary cases of syphilis in the USA and in North Carolina is as follows:

USA	1963	22,045;	1964	22,733;	1965	23,250
N C	1963	969;	1964	1,208	1965	1,138

The Committee recommends the following and suggests that the Society endorse these:

(1) Appeal to the private physician to report his cases.

(2) Demonstrate to him the need of epidemiologic follow up on these cases. Get him to use the intervening services of the local health department as well as diagnostic facilities including dark field.

(3) Promote various screening programs including an STS as part of routine hospital laboratory workup.

(4) Step up the V.D. teaching program in our medical schools.

(5) Take the problem to the people via radio and T.V. and programs in the schools.

(6) Promote epidemiologic treatment of contacts of infectious syphilis.

Howard P. Steiger, M.D., Chairman

EXHIBIT I

Exhibit I is presented for the guidance of the Utilization Review Committee in devising its own review form. It is suggested that this check-list be adapted to the type of records being kept by the individual hospital.

THESE RECORDS ARE FOR THE EXCLUSIVE AND CONFIDENTIAL USE OF THE
UTILIZATION REVIEW COMMITTEE

UTILIZATION COMMITTEE CHECK-LIST

This portion to be completed by medical record librarian.

Patient's Hospital Number
Age Sex
Length of Stay (Days)
Clinical Service(s)
Attending Physician(s) (Coded)
(If transferred, give all)
Day of week admitted (Monday, Tuesday, etc.)
If there was a consultation, indicate the number of days between:
 (A) Admission and request for consultation
 (B) Request for consultation and date answered
If surgery was performed, indicate the number of days between:
 (A) Admission and operation
 (B) Operation and discharge
Admitting Diagnosis
Complications, if any
Discharge Diagnosis

THESE RECORDS ARE FOR THE EXCLUSIVE AND CONFIDENTIAL
USE OF THE UTILIZATION REVIEW COMMITTEE
This Portion To Be Completed By Reviewing Physician

To Be Completed By Reviewing Physician—Please check the appropriate column. Give explanatory notes if “yes” or “no” answer suggest possibility of excessive or unnecessary use of in-patient facilities.

	Yes	No
1. Could services have been provided without admission?	()	()
2. Were diagnostic studies:		
A. Ordered as soon as possible after admission?	()	()
B. Provided as soon as possible?	()	()
C. Reported promptly?	()	()
3. Were any diagnostic studies ordered unnecessarily?	()	()
4. A. Does the interval between admission and the request for consultation appear to be too long?	()	()
5. Was the period between admission and operation prolonged?	()	()
6. Does the post-operative period appear prolonged?	()	()
7. If indicated, was transfer to another clinical service carried out promptly?	()	()
8. Were doctor's visits to the patient sufficiently frequent to provide promptest possible diagnosis and treatment?	()	()
9. Was hospital stay prolonged because of family or social factors?	()	()
10. Could the length of stay have been shortened by transfer to a convalescent nursing home?	()	()
11. Could the patient have returned home sooner through use of visiting nurse, homemaker or home care services?	()	()
12. Were discharge orders written at the appropriate time?	()	()
13. Could the length of stay have been shortened without adverse effects on the patient?	()	()
14. If the length of stay seems excessive, could the patient's "free" status or prepayment coverage have been a factor?	()	()

Summary of possible unnecessary utilization:

No action necessary
Referred to Utilization Committee M.D. (coded)
(Member of Utilization Committee reviewing the case)

Disposition by Utilization Committee:

No action necessary
Referred to: Director of Clinical Dept.
 Medical Record Committee
 Admissions Committee
 Executive Committee
 Pathology Department
 X-ray Department
 Administrator
 Attending Physician
 Other

If any matter pertaining to the case is referred for follow-up as indicated above, specify reasons, any recommendations made, and final disposition.

....., M. D. (coded)
(Chairman of Utilization Committee)

This report was sent to all hospital administrators by the State Board of Health on February 15, 1966.

The following letter with a set of the guide material was sent to all hospital chiefs of medical staffs and county medical society presidents on March 16, 1966:

The Utilization Committee of the State Medical Society has developed a brief guideline related to the activation and implementation of the Utilization Review Program required under Public Law 89-97 (Medicare). The guideline was developed in an effort to be of assistance to local medical staff personnel confronted with development of such plans.

Enclosed for your information is a copy of the guide material along with a sample Utilization Committee Check-List which may prove helpful in devising local review forms.

It should be remembered that this material is submitted as a guide only, with each facility being required to develop, in written form, its own Utilization Review Plan for submission to the State Board of Health as the certifying agency for Provider of Service in North Carolina.

SUGGESTED REFERENCES

1. Conditions of Participation for Hospitals—HIM-1 publication of the Department of Health, Education and Welfare, Social Security Administration. (2 copies sent by the State Board of Health to all Hospital Administrators.)
2. Utilization Review—A Handbook for the Medical Staff—American Medical Association, Council on Medical Service, Committee on Medical Facilities.
3. Mandatory Utilization Review—George W. Paschal, Jr., M. D., North Carolina Medical Journal, President's Page, January 1966, Vol. 27 No. 1.
4. Guiding Principles for Hospital Utilization Programs—American Hospital Association.
5. The Utilization Committee and The Medical Audit—Virgil N. Slee, M. D., Director of the Commission on Professional and Hospital Activities, Ann Arbor, Michigan.

NORTH CAROLINA BOARD OF MEDICAL EXAMINERS STATISTICS

November 1, 1964—October 31, 1965

Total number applicants granted license	406
By written examination	200
By endorsement of credentials	206
Limited license	92
Hospital residents	67
County or counties	15
State institutions	0
Special limited license	80
Hospital residents	50
Postgraduate foreign exchange hospital residents	30
Staff state institutions	0
Written Examination failure	10
Part I	3
Applicants for license	7
Applicants rejected license by endorsement of credentials	0
Applicants declined permission to take written examination	0
Hearings	28
Alcoholism	3
Alleged violation narcotic laws	9
Failure to comply with Vital Statistic Laws	1
Narcotic addiction	2
Surveillance as to narcotic addiction	3
Petition for reinstatement narcotic tax stamp	3
Petition reinstatement license to practice medicine	2
Addiction to amphetamines	1
Violation Internal Revenue Laws	1
RE Investigation by Medical Society Committee working with Industrial Commission	1
Criminal abortion and unprofessional conduct	1
Violation of conditions of suspension by the Board of Medical Examiners	1
Investigation State Bureau of Investigation	10
Violation of narcotic laws	8
Narcotic addiction	2
License to practice medicine revoked	1
Unprofessional conduct	
License to practice medicine revoked, judgment suspended	1
Narcotic addiction	
License to practice medicine voluntarily surrendered	1
Alcoholism	
Narcotic tax stamp surrendered	1
License to practice medicine reinstated	1
Recommendation to restore narcotic tax stamp	1
Declined to recommend reinstatement of narcotic tax stamp	2

A CALLED MEETING OF THE EXECUTIVE COUNCIL

THURSDAY MORNING SESSION

August 26, 1965

The Called Meeting of the Executive Council of the Medical Society of the State of North Carolina convened at ten-fifteen o'clock in the University Board Room of the Allen Building of Duke University in Durham, North Carolina, Dr. George W. Paschal, Jr., President of the Society presiding.

PRESIDENT PASCHAL: First, I would like to thank all of you for coming to this called meeting. You will have as few of these as I can possibly get away with.

Under these circumstances, I felt that the matters under consideration were of such importance that we needed united opinion, or opinion from all of us, concerning the matters that are on the agenda.

I thought that the matter under Item 4 which is under consideration here today, possibly has great potentiality, great impact, on the practice of medicine in North Carolina and the United States. Its impact might be even greater than that of the legislation which is already enacted.

We had little part in drawing up the legislation, as it now exists under Medicare. We have an opportunity at this time to seriously consider the implementation of a law which seems to be in the offing.

I recently learned that the Committee which is considering this legislation, is two short the number of votes necessary to get it out of the committee. Now, it might not get out of committee and it might not be acted upon this year, but in the event that it does become law, I feel that we ought to be in a position, here in North Carolina, particularly, to have some concrete ideas about how we want to participate in it if we're going to live under that legislation.

We have invited the Deans of the Medical Schools and others to participate in this as consultants, that would help to give us a broad conception of what is in order.

I might say, too, that we've invited the Vice Councilors of the different Districts to come and participate so they might be informed. They will have the privilege of discussion, which we welcome; however there will be only the single vote of the Councilor at the time we might vote on any of the questions.

I'll read Item 4 and we will proceed to that:

The implementation of Federal Legislation (impending) related to the establishment of categorical medical centers related to Cancer, Heart Disease and Stroke as envisioned in the DeBakey Commission Report to the President of the United States and encompassed in Bill S-596 and HR.

3140 now before the Congress and imminent of final action in the House of Representatives, currently.

(a) Report on the preliminary explorations of the representatives of the State Medical Society here on the Duke campus, Durham, North Carolina, August 10, 1965.

At that meeting, in addition to representatives from the Schools of Medicine in the State and including them, these were present: Dr. Anlyan, Dr. Barnes Woodhall; Dr. Beddingfield did not come—he was asked; Dr. Isaac Taylor was represented by Dr. Ernest Craige from the Medical School of the University of North Carolina; Dr. Jones; Dr. Mead; Dr. Johnson; Dr. Poteat; Dr. Raiford and Dr. Rhodes.

All of these were not in attendance at that meeting, but we did meet with them with the idea of exploring the feasibility of our participation in the impending and proposed legislation.

No action was taken. With deliberate intent, members of the Public Health Service and the Hospital Association, who will of course be intimately concerned with the implementation of this legislation, if passed, were not invited.

We had discussion by each of the three Deans, which was very helpful to our understanding of the problem. We had additional discussion by others, who were present.

Included among those who were there were Dr. Frank Jones, Dr. Rhodes, Dr. Poteat and Dr. Alfred Hamilton who came to consult at that time.

(Drs. Jones, Rhodes and Hamilton made brief remarks.)

(Dean Anlyan of Duke was called on.)

DR. ANLYAN: Now, as we look at S-596 which is really only a piece of the DeBakey Report and perhaps one of the more controversial pieces of it, there are some good features and there are some bad features.

One feature that is controversial in itself is the vagueness of the language of the bill and perhaps looking at it positively this is a good thing because this allows for each State or each Region to develop its own mold, its own planning, in a period of two to three years to see what is good for North Carolina, what is good for this region, rather than across-the-board categorical law that is—for example, the Medicare Bill which is the same across-the-board for the entire country, whereas in the legislation it allows for planning grants so that each area and each state can then continue with its own planning to see what is good for the health of North Carolina and what type of a mold should we develop.

Another good feature of the bill is that it would enhance communications between medical schools and the community hospital; first, by promoting even further postgraduate and continuing education.

I might stop at this point to say that even before this legislation appeared, Dr. Mead, Dr. Taylor and I had started what we call Project ICE.

It's fashionable today to find such names, but ICE stands for Inter-university Continuing Education. We thought it was ridiculous to be competing with each other in fields where we could more reasonably pool our resources and do a better job for the State of North Carolina.

Continuing Education was one of the areas we talked about long before this legislation ever appeared. Instead of having a symposium on cardiology one week at Bowman Gray, one week here and one week at Chapel Hill—each trying to outdraw the other—why not pool our resources so that it would enhance the communications between the medical schools, the community hospitals and the practicing physicians by supporting post-graduate and continuing education.

It would enable the community hospitals on a voluntary basis to hook up in closed circuit television, hot lines, telephone lines, with any of the three schools, with any of the three schools, with any of the areas that you would want to, voluntary and not mandatory, legislated from Washington.

Thus the physician practicing at the Craven County Hospital could at a moment's notice, either on a hot telephone line or hook up line, get immediate consultation with anyone he wanted; or he could pipe the fluoroscopic image of the part he was fluoroscoping to one of the centers and obtain an immediate consultation.

His electrocardiograms could be piped in to our triangle computers for immediate analysis and in milliseconds get a precise, mathematical analysis on the electrocardiogram.

The same thing could be done with the electroencephalogram.

This is not wide blue yonder thinking because all of these things are being done in a pilot way right now at our medical center.

A potential practitioner of medicine might be more likely to settle in smaller communities in North Carolina with this type of legislation.

The community hospitals or physicians could have a free choice of hooking up with any combination of affiliations with any of the three medical schools.

The specialists at each institution could be cooperating more vigorously than we have.

Now, what are some of the negative aspect of the bill as we see them?

There is a loophole providing financial care for demonstrations, research and training purposes. This can be abused and perhaps in the final rendition of the bill, it can be specified so that we will not get more and more patients who are let into the hospitals under this financial loophole.

Another drawback and negative aspect would be that this would demand an increase in medical manpower at both ends of the pipeline. One to work at the community hospital and the other at the

medical center.

If enough people pick up the hot line to discuss fluoroscopic image with George Baylin on the contour of the heart, we're going to need more George Baylins.

At the same time, we will be turning out more people, we're going to need more people, more practicing physicians, at the community hospital level.

Another negative aspect is the categorical nature of the bill; namely for heart, cancer and stroke, presumably because seventy-one per cent of the deaths in this country today are due to these three diseases.

What about the poor sibling and the man with the coronary artery occlusion; the sibling with multiple sclerosis—why should he be denied the same type of frontier, pipeline care?

Another negative aspect of this is that if Dr. Dempsey of HEW is correct, that ninety per cent of the construction funds apply only to the community hospitals and at the present time, initially would apply only to equipment and renovation only, you can't have a good pipeline with apparatus just at one end and none at the other. The pipeline ought to be a decent pipeline with good equipment at both ends.

Now, in closing I want to add that North Carolina today is in a unique position.

Dr. Mead, Dr. Taylor and I happened to become Deans at about the same time. We've been old friends and we decided early in the game that the future of medicine and medical education was too great for us to be carrying on some of the competition that was historically considered right in the last few decades.

I think, in other words, in concluding, that the climate here is unique in trying to work together for what is good for the State of North Carolina, in perhaps thinking of a grant of this type for planning to develop a mold that we can say is good for people of North Carolina, for the people of the Region, as well as our interest in the practice of medicine and in medical education.

(Dr. Manson Mead of Bowman Gray was called on.)

DR. MEAD: We felt it was important to get a planning grant, and if the plan was not acceptable we would not get the grant; if the federal government plan and their changes were not acceptable to us we need not go any farther. We couldn't lose anything.

Second, a very important point that came out was that we should proceed only with select planning with a segmented society and later bring in hospital administrators who would be involved and perhaps the Public Health Service and other welfare agencies.

So, we gave a report at the State Society meeting on our panel on medical education and I'd just like to read a pertinent portion of the report that we gave.

Current federal legislation, which proposes the development of regional medical complexes throughout the country for the research and treatment in heart disease, cancer, stroke and other major diseases places the major responsibility on medical schools to expand efforts in continuing education in research and patient care. Whether we like it or not, this legislation will have a significant impact on medical education, research and medical practice.

Therefore, representatives of the three medical schools have studied and discussed this and its many details. We are concerned about some of its implications.

If enacted, we feel it is imperative that the three institutions, the medical profession, the hospital administrators and the relevant health agencies plan together ways of implementation which will protect the freedom and dignity of the individual physician, preserve the primary functions and autonomy of our institutions and bring maximum benefits to the people of the State.

In essence, we feel that this bill can help us do more effectively what we're already doing. We feel it will help us to mount an effective program of education. We don't have the funds to do this now.

We do think by combining our manpower at three schools with funds to do this, we can implement Project ICE very rapidly to the benefit of physicians of this State.

Secondly, we think this will lead to much closer relationships between our community hospitals and our medical centers.

Thirdly, we think this will give us an opportunity to expand technical facilities, disseminate knowledge, in community hospitals throughout this State and throughout our medical centers.

(Dr. Ernest Craige, representing Dean Isaac Taylor of U. N. C., was called on.)

DR. CRAIGE: The law before the Congress is really quite different in many respects from the Commission's Report and is, as Dr. Mead has said, only a fragment of this whole report.

And, with the hearings that have been held, the bill has been modified and will be considerably modified in the future, if it passes, by the actions of the councils in the NIH which will be charged with this administration.

They, I'm sure, will be flexible in their attitudes as to how this is to come to pass and I believe they will invite imaginative proposals from the various states and this, I think, is where our opportunity comes in because if we form a study group here that can come up with a program that would be satisfactory and perhaps ideal for a rural state, I think they would welcome that and then we would have a chance to do something really original and make a great contribution towards the care of the patients of the State and towards medical education at the post-graduate level.

The Sanger Report, which as you may recall is

responsible for the increase of the schooling at Chapel Hill from two years to four years, definitely stated that our responsibility was towards medical care and post-graduate education throughout the State and we have considered that as our mission for a long time.

(Dean Anlyan was asked to summarize.)

DEAN ANLYAN: I think that Manson concluded implicitly with such a suggestion, that here we had an opportunity as a united group with the State Medical Society and the three medical schools and essentially with the other health agencies, to apply for a planning grant, should the legislation go through.

And, that in such a planning grant, we would spend two or three years trying to see if there was a mold that was good for the State of North Carolina and if this mold was satisfactory to us, it would then be submitted to Washington.

If the folks in Washington agreed with it, then everything would be fine. If they made suggestions that the planning group here considered to be acceptable to us, then we would go along with it. If their suggestions were not acceptable to us, then we would need to go no further.

So this would give us the opportunity, much like the Hill-Burton Act, for development at the local-state level of a mold that would be good for the State of North Carolina.

(Considerable discussion ensued.)

DR. JOHN R. KERNODLE (AMA Delegate): Mr. President, I would like to ask a question of the Deans, particularly since they brought out the description of the big brush of the Commission and other bills already written that will be hitting the hopper either this session or the next, of the 89th Congress.

Do you have in mind, if such a planning group is organized, to include in your survey the complete Commission's Report or is it isolated to Bill S-596 as it exists?

DEAN MEAD: I think there are other portions of this bill that are already in. For instance, there's a suggestion that there be additional assistance to medical education. This is in the form to help the professions. Construction money to help build schools. There's a library bill in there which talks about meddlers and the retrieval of information.

Various portions of the DeBaKey Report are in the form of several bills.

I would envision that if we have this advisory group set up, I see its implications are far beyond this. I think we have many problems in this State where if we had a means of good communication between medical schools and practicing physicians, organized physicians, this whole business of hospital costs and so forth, in many areas such a group, regardless of whether the legislation is passed, would be a very healthy thing for the State of North Carolina to have a good, solid means of communication between all of us who have a primary concern

in the better health of the people of the State of North Carolina.

PRESIDENT PASCHAL: I think this Executive Council wants to represent all of its constituents. It would appear to me that in time to come these services, these complexes as you might say, are going to be necessary whether you have this legislation or not; whether they become new complexes and whether they become part of existing facilities and we in medicine ought not to overlook an opportunity to cooperate and help direct and mold the course of the activities of both the practicing physicians, as well as those who are concerned with our teaching institutions.

DR. WILLIAM H. ROMM: I'd like to say that since this is a voluntary participation program, I personally would hate to go back to my district and say we didn't want to participate even in planning this thing.

I can see a big opportunity to improve the medicine in the rural sections.

DR. JOHN GLASSON: I have had proposals from the federal government for supplying funds for equally fine projects; projects for giving free school children, say, the opportunity to get some exposure to school life, to learn to listen to instruction where they've never had such instruction; fine objectives in every respect.

I have participated in the plannings that have been carried out and I've helped set up programs to carry out objectives for the education of our children, which in every respect was the very best that could be planned.

Here, we have a like situation where we're planning for the health care of the people of North Carolina and again, I want to emphasize that I think we should plan for that help and health care, but once the planning for these children was made, the plan was presented to Washington.

It was approved. About a week before the plan was to be implemented, the teachers for the program had gone to Chapel Hill to learn how to carry it out and everybody was enthusiastic about it, and then, just to show that everything isn't rosy in Washington, the Commissioner called us up and now said, "You have to take a colored teacher and put him in every white class and you have to take a white teacher and put him in every colored class or you don't get any money."

So, we found ourselves in a situation of saying "We'll compromise on the program regardless of the ability of these teachers and we'll do what you say in order to avoid ruining the whole program."

So, I don't feel that if we do plan this thing and if we set it up, that we are necessarily going to get a program which is in every respect the very best program we know how to set up because there are other influences in Washington besides the good health care of the people of North Carolina.

And, I feel it is not in opposition to setting up planning, but it is something that we've got to re-

member that things are not always just what we think they're going to be when you get right down to receiving the funds.

DR. W. OTIS DUCK [First Vice President of the Society]: Dr. Paschal, early in the reports from the Deans, I heard them repeat comments regarding these hot lines and so forth from the community hospitals that would be fed into the universities and it occurred to me that in some areas, particularly in my own area where we don't have any community hospital, I wondered if there is anything, any provisions, for any liaison between the rural practices of practicing physicians and these regional medical centers or complexes, directly from the physician's place of practice.

DEAN ANLYAN: Yes, very definitely.

As a matter of fact, many of the things that apply to the community hospital, can be done in the doctor's office in rural practice.

For instance, right now, we are computerizing our medical library, so that within two years—we need to run one year internally to make sure it works, but within two years, you can pick up the phone from your office and ask us for the latest literature, for either the titles, the abstracts, or the full article on any subject you want and you'll get it in the mail the next morning.

Within five to ten years, the apparatus that is available today—but it is not economically possible without this type of grant—with a gadget you can attach to your telephone, you'll be able to dial in or type on a typewriter connected from your desk right into our computer and it will spout it out within minutes to your desk.

Now, the problem we haven't solved as yet, is not the hardware. The hardware is available today to do this for you on a library service. It's also available today to pipe in the electrocardiogram that you take in your office and put it through the same channel back to your office, but what would not be available without such a bill, unless we are willing to put on a campaign within this State, is the money to construct and to buy this equipment and to install it.

DEAN MEADS: I would like to add—we're already making plans.

As you know, Chapel Hill has this radio program and we're extending lines to Bowman Gray and Duke to expand the number of people who participate in this and hopefully to expand it to every community hospital and then further on, to the doctor's office.

But, again, it can't be done without money. All these things that are coming are going to require financial support.

* * *

Here we sit by and say the hospital administrators got in on it—the Medicare Bill—and they formed for themselves what they thought was best for hospitals.

Now, isn't it a little asinine for us to sit down

and say we're not going to join you and help you form this thing because we don't believe it's any good?

Why not at least get in and try to work out something that's good for medicine and good for the practice of medicine in the State of North Carolina?

(After more discussion the three Medical School representatives left.)

DR. CHARLES S. PHILLIPS: There are members of our medical profession who oppose these regional medical centers and there are other members of our medical profession who feel they would benefit from them and Dr. DeBakey apparently is one of those who oppose this.

So, actually our own medical organization is not unified in its opinion.

It seems to me that we should certainly feel free to express our disapproval to our legislators who are in the process of passing this bill and I feel we should go on record—and I agree completely with Ed that we should not give our approval if we don't so approve.

But, I think we should be perfectly clear in expressing our objections to these regional centers if this is our opinion.

But, I think this is something we should do, is to let our government know that we do intend to co-operate with the legislation as it is passed and that we will do our best to plan.

I think it's well to have a planning council.

DR. RAIFORD: I'd like to ask Ed, too, what is your opinion of the feeling of the various Congressmen with respect to this?

DR. BEDDINGFIELD: I don't have any recent information with these summer doldrums, but I think whatever motion is put by whomever, at the time, I would like to see it not mention any specific impending legislation.

I have only talked about this specific bill that we're talking about this morning to one Congressman that happened to be my own, and he made the point that has just been made by Phillips over there, that most of the people who've heard this in Congress have heard from their members and from the members of the DeBakey Commission.

DR. JOHN RHODES: I doubt there are many doctors in North Carolina that would take exception to the benefits of the Hill-Burton Act. I believe it has touched the lives of every doctor practicing in the State of North Carolina and there are very few in close proximity to a hospital.

That was a voluntary participation on the part of the State and it was locally controlled.

We supported with all of our energy the Kerr-Mills Bill primarily because it was to be locally implemented and locally controlled.

Well, maybe we didn't support it vigorously enough because we got a federally centralized control program rammed down our throats.

As I understand it, the provisions of this bill make

it possible for a region or a state to participate in it on a voluntary basis.

Now, I'm perfectly aware and skeptical of things that come out of Washington, just like my friend Ed Beddingfield is. I think we ought to look with a skeptical eye at everything that comes out of Washington and I also am aware of some of the things that Alfred has said and some of the things that Charlie Styron has said, as they relate to the local, private physician.

But, I do believe that unless we have a voice in this thing—and I think it's bigger than this bill really and it has been properly stated. This is a bigger thing than the bill.

But unless we are prepared to have a voice and are prepared to have some part in directing what happens to medicine in North Carolina in the future, and unless we get some credit for it, then I think we are going to be left at the switch.

So, I feel like we must go ahead and I believe we can set up a planning commission without any reference to any specific bill whatsoever and I think that's the way it should be done and I'd like to see us take that step.

And, I believe that John Kernodle has a point that maybe we could do this without asking for a federal grant, but I think once the planning board is set up, I think then it could make the decision about how it wants to approach it.

PRESIDENT PASCHAL: I think this gives organized medicine a chance to take part in the planning and in trying to hold things in the future, and it was with that in mind that we hoped that we could come to some policy decision here today, as far as our participation in impending legislation or in any other legislation that might succeed it.

And, possible we could take action without alluding at all to any specific legislation bill.

Is someone ready to make a motion as to what we should do with this?

A motion that we endorse the principle of the planning commission or council that would make certain recommendations and advise the Governor, with the suggestion that this commission include certain representation from the public health department, the Hospital Association, the medical profession and that we should spell out in that how many men on the council or commission we would suggest.

DR. DUCK: Mr. President, I would like to make such a motion.

PRESIDENT PASCHAL: Is there a second?

DR. SHAFFNER: I'll second it.

PRESIDENT PASCHAL: Any discussion?

DR. STYRON: Mr. President, if we dilute the purpose of this study commission to include every piece of health legislation that effects North Carolina, we're also going to dilute our effectiveness, in this report which is what we're talking about.

On the other hand, and how this can be done without saying we favor such a bill is something else

again, but on the other hand, if we create another commission with the teaching and practicing physicians and have a committee that is to encompass everything that comes out of Washington, I believe we're going to miss the whole point of the meeting because we came to discuss the DeBakey Report. This is what we're interested in and this is the big item that we want to be effective in if it comes to pass.

Now, how you can do this without signifying that we hope the bill will be passed, or that we don't hope the bill will be passed, is something else again.

We'll probably have to call on John to word such, but I would oppose such a motion that gives us a commission that's responsible for everything because I think if we do this, we miss the whole point.

I'd like to offer a substitute motion that the council go on record as favoring a study commission for discussion and implementation of Bill H.R. 3140 in the event that it is passed.

This commission can be expanded, but this is what we're talking about, this is what we came for.

DR. BRINN: I second the motion.

DR. SHAFFNER: I would envision that what Charles is talking about in his motion would really be a committee from the State Society working with the deans of the medical schools as to what type of commission we would recommend, if the bill is passed and then we would recommend to the Governor, if one could receive the grants.

In other words, this would be a non-governmental committee that cooperates with the deans—you talk about all these problems and then if the bill is passed, then that committee would recommend to the Governor what this commission should be.

DR. STYRON: And, could further recommend what specific individuals the Governor should appoint.

DR. SHAFFNER: In other words, you've got two committees. You've got to study before it is passed and have recommendations ready. Then, if it is passed, we've already talked over from the Medical Society point of view and the medical school point of view; then, you can go to the Governor and say this is what we recommend to implement this part in North Carolina and be the ones ready to receive a grant.

DR. PASCHAL: I believe, if it meets with your approval, you leave these motions on the floor, and return after lunch and consider action on them.

]The meeting recessed at twelve-forty o'clock:—

THURSDAY AFTERNOON SESSION

August 26, 1965

The Called Meeting of the Executive Council of the Medical Society of the State of North Carolina reconvened at one-fifty o'clock, President George

W. Paschal presiding.

PRESIDENT PASCHAL: Let's reconvene and we will continue with consideration of problems at hand.

There was a motion on the floor and an amendment and a substitute motion was made after that.

Would you like to have those motions read, or do you think you know the extent of them?

DR. BEDDINGFIELD: I'd like to offer also another substitute motion.

I have worked this motion which I hope sets down an acceptable compromise to the various points. I've worded this in the form of a resolution, without being too verbose.

WHEREAS, there have been recent advances in medical research, education, diagnosis and treatment of various diseases, and,

WHEREAS, it is the sincere desire of the Medical Society of the State of North Carolina to bring to the people of North Carolina the best possible health care, and,

WHEREAS, many new proposals for accomplishing this end are appearing on the national scene and other proposals are anticipated, and,

WHEREAS, we believe that these recent advances in medical research, education, communications in patient care should be carefully evaluated and the most desirable of these programs be made available to the people of North Carolina,

Therefore, it is,

RESOLVED, that: (1) the Medical Society of the State of North Carolina hereby establish and encourages the participation of others in the formation of an advisory council of health professions.

(2) the council shall study any and all methods of achieving improved health care for the people of North Carolina and periodically report its findings and recommendations,

(3) the council shall be composed of ten members as follows:

1. The Dean or his representative of each of the accredited medical schools of North Carolina,

2. Three physicians appointed by the President of the Medical Society of the State of North Carolina.

3. The State Health Director, or his representative.

4. The Executive Secretary of the North Carolina Medical Care Commission.

5. Two representatives of the North Carolina Hospital Association.

I move the adoption of this substitute motion.

PRESIDENT PASCHAL: You've heard the motion, substitute motion, that this resolution that Dr. Beddingfield read be adopted.

Is their a second to this?

DR. GARRARD: I second the motion.

PRESIDENT PASCHAL: Is there any further discussion?

DR. BEDDINGFIELD: We are sponsoring par-

ticipation of others in a multi-disciplinary group between the Medical Society, the Hospital Association, the State Department of Public Health, where we are showing the initiative and leadership in establishing this.

Dr. Paschal will appoint our members and we will invite and encourage the participation of others. I think we already have the schools where they would send their participants for membership and I feel the others would, too.

DR. MURPHY: This would report to whom?

DR. BEDDINGFIELD: Well, certainly the three physicians would report back to this group, I mean we would be adequately represented, so they would report to the Executive Council.

It would be part of a regular committee report, I think. We have reports from physicians, from the Medical Care Commission, for example.

DR. GLASSON: Would they be eligible for planning funds?

DR. BEDDINGFIELD: That's neither prohibited nor specifically included in there.

DR. STYRON: Well, I would like to withdraw my substitute motion in favor of this because I think this is a reasonable compromise.

PRESIDENT PASCHAL: You've heard Dr. Styron's decision to withdraw.

DR. DUCK: I withdraw my original motion, but actually if we vote on the substitute motion that kills both of them anyway.

PRESIDENT PASCHAL: All right. Are you ready for the question?

All in favor of Dr. Beddingfield's substitute motion and resolution, let it be known by saying "aye"; opposed by like sign.

That's passed and that will be recorded as such; passed without dissent.

DR. SHAFFNER: Does this Council need to take any action on the implementation of this, to get this thing started, to put this into effect?

PRESIDENT PASCHAL: We can institute it ourselves and I think this will satisfy the deans as well.

I know all of you have a long ways to go and we don't have very much more for your consideration.

I do have Item 5:

Expression to State Government of a recommendation as to the designation of a state agency by the State for the administration of the provisions of Public Law 89-97 related to hospitalization, medical care and related services under this new Act.

And, (b),

Expression to State Government of a recommendation as to state agency used in developing conditions of participation for providers of services and to determine compliance by providers of services with conditions of participation.

That's a bunch of parasyllables that we used but we want to make a decision here this afternoon

as to what state agency we want to support, or recommend, to supervise the administration of this new legislation.

(Discussion.)

DR. LENOX D. BAKER [North Carolina State Board of Health]: George, we just held our meeting over there and we got over here as rapidly as we could.

I called over to see if I could get some of the feeling that was over here because we didn't want to act and then have to back up if we didn't have your support.

I was in the Governor's office this morning and told him that I wanted to speak to him about it and told him I thought I was expressing the feeling of the medical bureau, that Medicare when released would have to be administered and controlled.

And, as far as I was concerned there was only one group of people in the world that could handle it with guidance and control and that would be doctors because they're the ones who put people in the hospitals.

I told him that we should go very carefully and investigate this thing.

DR. FRANK JONES: I move you, sir, that the Medical Society of the State of North Carolina recommend to the Governor of the State of North Carolina that the State Board of Health be designated as the agency for the administration of the provisions of Public Law 89-97 as it relates to hospitalization, medical care and related services under this Act; those functions that it could perform.

Dr. Raiford seconded the motion.

PRESIDENT PASCHAL: Is there further discussion on this motion?

DR. GLASSON: I'd like to ask how the State Board of Health would go about giving the benefits to the individual person who receives the money.

DR. BAKER: It would have to be through social security. The Social Security Agency handles the money. That's where the money comes from.

DR. GLASSON: I know where it comes from but how does it get to the patient?

Does the State Board of Health write the check?

DR. BAKER: Well, as I understand it, we made Kentucky put it into Blue Cross and Blue Shield and various states have done various things.

DR. BEDDINGFIELD: When you talk about the fees that are allotted to physicians for patient care, reasonable fee, this is subject to very elastic interpretation.

As I understand it under one plan, this may either be an indemnity fee, or a service plan, if the patient assigns the benefit to the doctor. Then you accept this just like a service plan, just like insurance.

If you let the check go to the patient, you send in your regular fee. You can charge whatever fee you want to but in interpreting what is a reasonable and customary fee, I think it would relate to

what we're talking about.

PRESIDENT PASCHAL: Is there further discussion on this?

If not, are you ready for the question?

All in favor of this motion let it be known by saying "aye"; opposed like sign.

The motion is carried without dissent.

DR. KERNODLE: I'll just take a moment of your time and bring to your attention a thought that's being passed around at the House of Delegates of AMA, and I think it is the business at hand for you.

One of the States in the south, Texas, has circularized a few of the delegates asking them to consider the activities of holding a special session of the House to take consideration of the Medicare Bill.

There are people in this country and in this State who have called me and have called Amos wanting us to take action to take no part in the Medicare implementation and that is really what this whole request is for, from the Texas delegation.

It takes seventeen states to call a special session and twenty-five signatures.

(Discussion ensued.)

DR. KERNODLE: I would take from the consensus of expression here that you don't want to take any formal action.

DR. BEDDINGFIELD: I think it would be well to formalize this direction that it's the feeling of our members here; otherwise, we wouldn't have anything on the record.

And, if I may, I make a motion to the effect that the Executive Council go on record as not favoring a called meeting of the AMA House of Delegates prior to the next regular meeting.

DR. RAIFORD: I second it.

PRESIDENT PASCHAL: You've heard the motion. It has been seconded.

(The motion carried without dissent.)

(The meeting adjourned at three-thirty o'clock.)

SUNDAY MORNING SESSION

September 26, 1965

The Fall Meeting of the Executive Council of the Medical Society of the State of North Carolina convened at nine-two o'clock in the Crystal Room of the Carolina Hotel, Pinehurst, North Carolina, Dr. George W. Paschal, Jr., President of the Society, presiding.

PRESIDENT PASCHAL: Let us come to order, please.

(The Secretary called the roll and declared a quorum present).

PRESIDENT PASCHAL: Thank you, Mr. Secretary.

I would point out at this time that Mark Lindsey is not here. He is away because of illness; nothing too serious however. His Commission is going to be covered by Dr. Kernodle who will report on the

activities of the committees under his Commission.

It is with considerable regret and sadness that we have learned of the resignation of Dr. Brinn. He wrote a letter of resignation to which he had an answer. He is being replaced by Dr. Romm and we're delighted to welcome him to the Council.

(Mr. Barnes made a brief report of August meeting.)

Mrs. C. Henry Sikes, President of the Women's Auxiliary to the Medical Society gave a report on the year's program on the theme "Keys to becoming a successful doctor's wife."

Highlights included:

(a) Membership of 2,516.

(b) Fall Workshop in Greensboro.

(c) Regional Workshop in Atlanta as guests of AMA.

(d) A January panel discussion is planned at Pinehurst.

(e) Mental Health Fund of \$6,879.50, on a goal of \$10,000.

(f) Student loans of \$3,500.

(g) Four sanatorio beds endowed.

(h) A program of safety education.

(i) Membership bylaws changed to conform with Medical Society.

(j) A part-time headquarters secretary requested.

Auxiliary president-elect Mrs. Leon Robertson was recognized, as well as new headquarters staff member Bryant Paris.

Dr. Wayne Benton, chairman of the Finance Committee, presented the budget as of the end of eight months, with slightly more advertising revenue and an apparent deficit for the year of about \$1,000.

Dr. Benton recommended changing the Society's invested funds to more common stocks instead of bonds.

The budget was adopted as presented.

A motion was made, seconded, and passed to amend the budget to include the part-time secretary requested by the Auxiliary.

Dr. Hewitt Rose presented a report of the Headquarters Facility Committee.

DR. HEWITT ROSE: Gentlemen, I'll first give you a brief history of the Headquarters facility committee, to bring us up to date on what has been considered previously.

The headquarters Facility Committee first met in 1955 and recommended that the Society acquire a building site on the Raleigh-Durham Highway, Highway 70; a 52-acre tract at a cost of \$26,000 was purchased in 1956.

A brochure with an outline of a building costing some \$350,000 was prepared for the Executive Council, House of Delegates, at the 1957 meeting.

The Executive received the Committee report without recommending action.

In 1958, the Committee recommended to the Society to consider a proposal to locate headquarters facility at Research Triangle. This was decided against in favor of seeking residential property

within the city of Raleigh for temporary use, with the ultimate plan being to build on the Highway 70 tract.

No such property was found to be available.

An inquiry was made into the possibility of building with or leasing to other health organizations, with negative results.

The 1959 Committee recommended building on Highway 70 and exploring the construction of a modern, efficiency type building, rather than the more artful structure previously considered.

Additional space was obtained at the overcrowded facility at the Capital Club Building.

It was the accepted recommendation of the Administrative Commission Chairman that the Committee on the Medical Society's Headquarters Facilities be dissolved since the question of building would be dormant for the time being.

Because of numerous inquiries recently, Dr. Paschal has reactivated the Committee for consideration of building our own headquarters facility.

There are several compelling reasons why we should build at this time.

One: The Society should have adequate space and room for future needs of offices, meeting rooms, and a place furnished in a manner in keeping with the dignity of the profession.

Two: The present facilities are inadequate.

They occupy 3600 square feet at a rent of \$2.26 per square foot which is \$8,436 per year. It is the cheapest sizable office space in the Raleigh downtown area and it gives that impression to the occasional visitor.

The present staff is being necessarily increased and there is not enough space for them.

The one meeting room is small and will accommodate only a dozen people. For many of our Committee meetings, this room is inadequate.

Obtaining additional space in the Capital Club Building is doubtful.

Parking anywhere near the facility, during business hours, is impossible. Without rented parking space, the area is almost inaccessible.

Three: The Internal Revenue Service has recently questioned tax exempt organizations building up funds. Specifically, they have questioned the continued tax exempt status of the North Carolina Medical Society due to the funds built up in mutual funds and land speculation.

From this standpoint alone, this would be a good time to sink our surplus into a headquarters facility building.

Several areas were investigated for building.

The Highway 70 tract, I'd like to consider briefly, first.

Building on Highway 70 tract, the Raleigh-Durham Highway, would be undesirable. This land is eleven miles from Raleigh and does not have city bus service for headquarters facility employees. We would very probably lose some or most of our

present efficient staff if we located our offices at this site.

Because of the location in Raleigh recently of several large companies, good secretarial help is becoming more and more difficult to find.

At all times, and especially during the State Legislative Sessions, the Executive Secretary and his aides need easy distance, preferably walking distance, to the State Legislative Buildings.

Several sites within the City of Raleigh were considered.

The first tract is 106,000 square feet on Wade Avenue. This is about three miles from the Legislative Building. This could have been bought six months ago at 90 cents a square foot or \$100,000.

This does not meet our proposed requirement that the facility be within walking distance to the Legislative Building.

There is a 165 foot by 230 foot available site on Oberlin Road which is about two blocks from the Wade Avenue site. This is available at \$2 a square foot or \$75,000.

There is a 44-1/2 by 148 foot lot to the Andrew Johnson Hotel available for \$90,000. This, I think, is undesirable because of the parking difficulties and the lot is really not large enough.

There is some Redevelopment Commission property available within walking distance of the Legislative Building. I have a list of the recent sales of this property, which range from \$1 to \$1.82 per square foot.

This property was looked over and several of the areas closer to it and including this particular piece are zoned "industrial" and I would be very much disinclined to build in an industrial area when the light industrial property that will be built next to us may be very undesirable.

The last place to consider is a place at East North Street and Wilmington Street.

There is a 240 foot by 150 foot lot which is 36,000 square feet, available at \$2.50 per square foot, or \$90,000.

The latter of these locations seems so much more desirable that we had an architect, Mr. Charles W. Davies, Jr., of Raleigh draw up a feasibility plan for building on this property, which is represented by the map going around.

You will see from the study that a two story building and 10,000 square feet leaves very adequate parking, as well as additional space for attractive landscaping.

The one block distance from the State House, shown on the street map, on the right-hand corner of the map is to be noted.

This property is being held by the owners for the Medical Society until Monday morning.

Adjacent to the property, there is a smaller lot which has been sold in the last year for \$4 a square foot. An office building has been put on this site.

Other available land in the area is either undesirable, or is much higher priced.

Financing of the building within walking distance of the Legislative Building with plenty of parking is feasible.

The tract purchased for building in 1956 on Raleigh-Durham Highway at \$26,000 was recently valued at \$163,500. This estimate is an immediately saleable price.

In 1959, the Society purchased mutual investors stock in the amount of \$103,000. The present value of this stock is \$156,000.

These two assets total \$319,500.

Mr. Davies, the architect, stated that a building within our probable standards could be built for \$20 a square foot, or \$200,000.

The building and land would total \$290,000.

It is the recommendation of this committee that the Wilmington Street property be purchased for immediate construction of a headquarters facility building.

DR. WELTON: Mr. President, I wonder if you might consider this proposal in two parts.

There's a good deal of speculation here which cannot be answered in a few minutes, about building costs and financing it, rates and so on.

But, it seems to me the thing we're immediately faced with is the desirability of tying down option on this land.

That's what we should concern ourselves with right now; what to do with the land can be decided later.

From what we've been told, it appears the land available downtown and the one recommended by the Committee, is at a bargain price and we might consider it simply from the standpoint of a good investment as recommended by our Finance Chairman.

And, undoubtedly, this land is at a bargain price now and whether we build on it or not, most likely it will appreciate within the next few years.

As I understand it, we're not called upon to take any action upon the building itself at this time, but in order to get the land, we have to give a decision by Monday. Is that correct?

DR. ROSE: Yes.

DR. WELTON: I suggest we consider that part of it.

PRESIDENT PASCHAL: Thank you, Dr. Welton.

It is important to come to a decision as to whether or not we want to take an option on this property and we do have a deadline for that.

(A discussion of tax angles, rising property values, etc., ensued.)

DR. BEDDINFIELD: Mr. President, I move that the Society proceed to secure twelve months option on this property at the most favorable terms to the Society.

DR. SHAFFNER: I second the motion.

PRESIDENT PASCHAL: You've heard the mo-

tion. It has been duly seconded.

DR. WILLIAMS: Is that an open option?

DR. BEDDINFIELD: An option at the most favorable terms to the Society.

DR. PASCHAL: Are you ready for the question?

All in favor of Dr. Beddinfield's motion, let it be known by saying "aye"; opposed by like sign.

The motion is passed.

I would like to thank Dr. Rose and his Committee for the work that they've done and we'll look forward, with interest, to hearing from your further.

In line with the report of the Committee on Finance I call your attention to Item 14 on our agenda which has to do with dues billing, and under that is "Responses from county medical societies".

MR. BARNES: In July, we sent to each of the county medical societies a query as to whether or not they would have the headquarters office bill for and collect, county medical society dues and remit them in a lump sum, or whether they would elect to do it themselves.

Now, 26 out of the 77 counties have made returns to indicate they would prefer to collect their own dues and 20 counties have indicated they would prefer the headquarters office to collect their dues and most of them have expressed the level of their dues in this return, so a total of 46 out of the 77 have reported.

We requested them to report to us by the 10th of September so this is the incomplete response from the component societies, as of now; 46 out of 77.

(Discussion ensued.)

PRESIDENT PASCHAL: Would you like to have Mr. Barnes go ahead and do the billing that he has been asked to do and then continue as we are.

I judge that requires no motion. Mr. Barnes has authority to pursue that already.

Suppose then we pass on to the next item, Item (b), "additional staff personnel", which has to do with an executive for Med-Pac and a part-time secretary for the Auxiliary.

We've talked about the part-time secretary for the Auxiliary, but I'd like to recognize Dr. John Rhodes at this time to speak about that.

DR. RHODES: Mr. President, Members of the Council:

I think passage of the Medicare Bill and pending enactment of the DeBaKey Bill makes it pretty evident to all of us that the influence of the federal government on medical practice is mushrooming.

We need funds to support our activities.

You've heard from the President of the need for funds for the activities of the Auxiliary. Well, certainly in the organization which expects to contact and distribute material to the membership of the Society, we'll need some support financially.

We can't use that for candidate support, but we do need it to set our organization up, to get it going and hold workshops for members of the organiza-

tion.

There is continuing expense such as secretarial and otherwise.

So that we come to you with the request that we be considered in the budget for a sum up to, I would say, initially of \$1,000 to implement this program.

(Mr. Ed Smith of Virginia, new regional agent for Am-Pac in the Southeastern U.S., commented on progress in his area.)

DR. JOHN KERNODLE: I attended the opening of the Kentucky Medical Association's annual meeting in Louisville as a guest speaker on the Kam-Pac banquet program of Monday night. I attended the Council meeting on Sunday and the House of Delegates on Monday and to my most gracious surprise, I found that out of the 2100 members of the Kentucky Medical Association, over 870 are members of Kam-Pac.

At the banquet on Monday night, there were 350 or more people in attendance.

The enthusiasm is extremely high.

They have a full-time employment basis. They have their Executive Secretary of Kam-Pac across the hall of the Executive Director of the Kentucky Medical Association.

I point these things out because there is a terrific amount of enthusiasm in the states I have visited and this was the most recent one.

I do hope we will realize our position and as has been pointed out by John Rhodes, you cannot dismember this body by removing its arm which is so strong at the moment in our Medical Society.

PRESIDENT PASCHAL: Thank you, Dr. Kernodle.

John, do you have any recommendations as to any action that the headquarters staff should take at this time?

DR. RHODES: Well, Mr. President, I believe it has been stated here before that the Council is responsible for setting policy and I did not approach the Finance Committee on that account because I felt that this would be a policy decision.

My Board would like to recommend to the Council that we be afforded some help within the Medical Society office, at least the division of some person's activities in support of Med-Pac and that we be allotted a sum of up to \$1,000, initially, for the purpose of promoting a program.

That would be our recommendation.

PRESIDENT PASCHAL: You've heard the recommendation—

DR. RHODES: I would point out that the funds will be entirely separate from membership funds, kept entirely separate, and be used only for educational purposes.

DR. KOONCE: I would like to make that in the form of a motion.

PRESIDENT PASCHAL: Is there a second?

DR. DUCK: I second it.

PRESIDENT PASCHAL: I have the impression that the House of Delegates rejected the idea of

contributing any substantial amount of money to an educational fund, two years ago.

I didn't want this Council at this time to be in the position of circumventing the action that was taken at that time.

DR. RHODES: We're fully aware, Mrs. President, of that action and that is one reason why we did not bring a recommendation for an overall fund. We only requested enough funds to support the promotion of our organization to get it off the ground.

PRESIDENT PASCHAL: Thank you, Dr. Rhodes. I just wanted to have it clear in my own mind.

Is there further discussion?

If not, are you ready for the question?

All in favor of the motion as made by Dr. Koonce, let it be known by saying "aye"; opposed by like sign.

The motion is carried.

MR. BARNES: I would like to, just for the clarity of the operation of the headquarters staff—does this mean if I am requested to do certain functions for Med-Pac in North Carolina, that I will have the opportunity of assigning some voluntary staff effort to that sort of production in the headquarters office, as a function of Med-Pac rather than as a function of the headquarters of the State Medical Society?

Is that precisely what it means?

This morning, Mr. Ed. Smith comes in from the Virginia central office as a paid member of the Medical Society of Virginia. He functions that day for the Medical Society of Virginia.

If there is anything to do for Vam-Pac, he volunteers to go into that setting and to function. He's not paid any additional amount for that but his time obviously is taken from time that he may have done functions for the State Medical Society.

That's roughly what you do in Virginia, as I understand it, isn't it?

MR. SMITH: Yes, sir.

MR. BARNES: And, several other states.

But there's no actual allocation of that time to Med-Pac, no reckoning of that time, monetary-wise in the Virginia State Medical Society budget.

MR. SMITH: Right.

The Medical Association of the State of North Carolina as a corporation is prohibited by Section 610 of the Federal Corrupt Practices Act, from providing anything of value to a candidate for office or a campaign, so that your staff personnel must be an employee paid for full-time by the State Medical Society of North Carolina.

What he does in the office for Med-Pac would be done under the same agreement. He would still be paid by the Medical Society.

Any activity that is done to educate doctors of how to join Med-Pac, or to join in political participation, is paid for out of those political funds.

That cannot be out of candidates support fund. If you do not have political education money from

corporate contributions, you must pay the bills out of the money that is collected from the individuals.

MR. BARNES: From Pac individuals.

MR. SMITH: From membership, that's right. In so doing, you dilute your effectiveness in campaign activities because this is the only money you can give this candidate support.

At this time, we will have the report on the legislation activities by Dr. Beddingfield.

DR. BEDDINGFIELD: Very briefly, I'll review those activities of the recently adjourned 1965 General Assembly with particular reference to we have an especial interest.

those measures considered by the Assembly, which

I have these listed, first of all, as legislative objectives accomplished.

- 1—Amendments to sterilization Law.
 - 2—Kerr-Mill appropriations maintained.
 - 3—Drug program implemented.
 - 4—Defeat of appropriation to help State Board of Health assist local departments was a blow.
 - 5—Good Samaritan Act passed.
 - 6—Nurses Practice Act was re-written in satisfactory form.
 - 7—Bill to certify and license psychologists was stopped before introduction.
 - 8—Amendment to Chiropractic Act was defeated.
 - 9—Bill to add dentists fees to medical insurance was passed.
 - 10—A similar bill concerning optometrists was also passed.
 - 11—A committee was appointed to study the schools of osteopathy.
 - 12—A bill to permit free disposition of organs and bodies was unfortunately defeated.
 - 13—Considerable interest was generated in a movement for state subsidy for the three-year diploma schools of nursing.
 - 14—A state commission on the aging was created.
- In National Legislative Activity:
- 1—Medicare passed.
 - 2—AMA has scheduled meetings to negotiate with government agencies regulations implementing Medicare.
 - 3—Social Security for doctors, retroactive to January 1, was passed.
 - 4—The Heart, Stroke, Cancer legislation was drastically amended, and the group authorized by the August Executive Council is ready to be activated.
 - 5—An antivivisection bill lodged in committee after considerable effort by the Medical groups.
 - 6—Health Professions Act of 1965 passed.
 - 7—A slightly ambiguous Drug Control Act was passed.
 - 8—Recommendation that Medical Society sponsor eleven scholarships to U.S. Chamber of Commerce-sponsored meetings with government leaders in Washington in January.
 - 9—Members of the Society should be altered to

new unemployment tax legislation to cut required employees from six to one.

DR. PASCHAL: I have a telegram from Manson Mead, Dean of the Bowman Gray School of Medicine, Dean Isaac Taylor of University of North Carolina Medical School and Dean Anlyan of Duke, and it reads as follows:

"Since our last joint meeting, it has become more probable that Senate Bill 596 as amended will be enacted in this session of Congress.

Since this legislation carries grave responsibilities for the three medical schools and organized medicine, we ask that you designate three representatives of the Medical Society to join us as members of a planning committee and that they have the necessary authority to develop plans which would make it possible for us to take full advantage of the opportunity we foresee to help the people of North Carolina. Such planning would not be binding to either the schools or the Society and subsequent application for its implementation would necessitate joint approval of the plans by both groups.

Such immediate action would in no way imply endorsement by the Medical Society of impending legislation, but would obviate hurried planning subsequently.

At the same time, it would give the State of North Carolina the proper role in state and national leadership in medicine as was the case in the Hill-Burton Act."

Now, this was obviously written before they had information that the bill had been approved by the Congress.

It is my understanding that while one of them does object to the resolution that we adopted, and while our resolution, if implemented, would afford them the opportunity to do all of the things they want to do now.

I get the impression that they feel this small group of representatives from the Medical Society working in conjunction with them, would give them somewhat of a head start on planning and making provisions to take advantage of the opportunity that is now going to be in existence as soon as the President signs the bill when it reaches his desk.

I rather think acquiescing to their request would add to the rapport that we already enjoy.

I bring this to you for your information and for your direction. I would be interested to know if you would be agreeable to having your President comply with this request.

DR. BEDDINGFIELD: I see no objection at all to the Society going on record as allowing you, endorsing the fact that you appoint three people to meet with the deans. I'll so move.

DR. MURPHY: I second the motion.

PRESIDENT PASCHAL: Any further discussion?

SECRETARY STYRON: Mr. President, you've still been directed to appoint this other committee.

PRESIDENT PASCHAL: Yes, that's true.

DR. BEDDINGFIELD: But, no deadline on it.

PRESIDENT PASCHAL: There's no deadline on it and any action on it has been deferred because of the fact that the bill has not yet become law.

Are you ready for the question?

All in favor of the motion made by Dr. Beddingfield, let it be known by saying "aye"; opposed by like sign.

That motion is carried.

Now, in continuation of something that has to do with legislation and with the permission of the Commissioner of the Commission on Advisory and Study, I would like to ask Dr. Rogers, or the Commissioner, or both to speak on Item B-6, which has to do with the report of the Blue Shield Committee.

DR. MAX P. ROGERS: Mr. President, Members of the Council:

Your Committee on Blue Shield met with a most voluminous agenda to cover. That required our attention on to the wee hours of the night and we had some very brilliant and interesting discussions and these discussions were augmented by the presence of our President, other members of the Council and in addition to this, we had two members with us from the National Blue Shield Plans: Mr. Parrish and Mr. Knebel.

A great deal of work was done, but it all evolved into two main features that we would like to present to the Council for your study and recommendation.

The first of these concerned a new concept of prepayment which has been under study for some time and has also been a working type of thing in various areas of the United States.

This so-called Prevailing Fee Concept was brought to our attention by Mr. Parrish, was presented to the Blue Shield Committee and it was discussed at great lengths.

And, as a result of this, we have a feeling in the Blue Shield Committee that additional studies should be done and that if we are to be a forward-moving group in the field of prepayment insurance we should spend more time with this.

So, therefore, following presentations by the National Association of Blue Shield Plans concerning the prevailing fee concept of allowances for professional services, the Blue Shield Committee by motion and unanimous vote recommends to the Executive Council the authorization of an in-depth exploration by the Blue Shield Plans of the prevailing fee concept.

This involves determining individual physician charges for services to usual private patients.

The Committee assumes that the exploration will be on a pilot basis in a limited geographic area and will be done with the full cooperation of the county medical groups within the areas involved.

This is our first recommendation to the Executive Council.

We have already had the implications of the cloud of Medicare hanging over us and what this

might do to us and what this is going to mean to us.

We discussed this at great lengths in the committee and in order to save time, I would like to present to you the following statement prepared by your committee for your perusal.

1. The Blue Shield Committee has studied in depth the implication of Medicare as it relates to the future of medicine in North Carolina.

2. Public Law 89-97 states that carriers are to be designated to administer Part "B" of this Public Law and that such designation will be done by the Secretary, Department of Health, Education and Welfare.

3. By reading the law we see that the responsibilities of these carriers are:

(a) Fee Schedules — to determine reasonable charges by physicians.

(b) To account for all monies spent.

(c) To audit all accounts of payments.

(d) To be responsible for proper utilization of the Medical Program.

(e) To serve as a channel of information relating to the program and

(f) otherwise assist in the administration of the program.

These are the duties now of that carrier which will be designated by the Secretary of HEW.

4. In light of these responsibilities, it was agreed in the Blue Shield Committee that if medicine is to indicate a preference for its carrier under Part "B", Public Law 89-97, it should act promptly since there remains little time for organization and planning.

While the law allows the hospital to designate their intermediary carrier, the Secretary of Health, Education and Welfare will name the administrator of Part "B".

Successful implementation of the program, however, requires participation by physicians and thus, it is likely that the Secretary of HEW will give serious consideration to an informed choice by organized medicine of a carrier for Part "B".

5. Therefore, in light of the fact that the two approved Blue Shield Plans of North Carolina have had a close working relationship with the Medical Society of the State of North Carolina for some thirty years and since our two plans already have systems of claim administration, communications and computer systems that will meet the criteria as established under Public Law 89-97, and since one of our plans has considerable experience in handling governmental programs, your Blue Shield Committee presents the following resolution to the Executive Council:

Be it,

RESOLVED, that the Blue Shield Committee of the Medical Society of the State of North Carolina recommend to and urge the Executive Council of the Society to recommend the two Blue Shield Plans of North Carolina as joint carrier

for administration of the benefits of Part "B" of Public Law 89-97 and that the Council communicate the resolution under an appropriate carrying letter to the Department of Health, Education and Welfare.

It was also voiced within the Committee that the Medical Society support the designation of the companion Blue Cross Plans as joint carriers for Part "A", Public Law 89-97.

It has already been pointed out, that time is short and since time is of the essence, we also offer for perusal by the Executive Council, a model statement which sets forth our position, which can be used to petition the Secretary of Health, Education and Welfare.

This is a petition that was forwarded to Secretary Gardner by the Nebraska State Medical Association and can be used as a model for a petition.

PRESIDENT PASCHAL: I think it's important enough that you should read it.

DR. ROGERS: This is the letter, the model petition, signed by Dr. Arthur J. Offerman, President of the Nebraska State Medical Association to The Honorable John W. Gardner, Secretary, Department of Health, Education and Welfare, Washington, D. C.

Sir: Nebraska Medical Service, the approved Blue Shield Plan for the entire State of Nebraska, respectfully petitions for consideration as a carrier as permitted and authorized by Section 1842, Public Law 89-97, 89th Congress, H.R. 6675, July 30, 1965.

In support of our petition, we are prepared to submit whatever information may be required regarding financial responsibility, legal authority, and any other matters which may be considered pertinent to our ability to perform all obligations required, efficiently and effectively.

Enclosed for your consideration is a copy of the Resolution passed by the House of Delegates of the Nebraska State Medical Association on April 28, 1965—this is similar to the resolution we just presented—by which the medical profession in the State of Nebraska has formally indicated an informed carrier preference under the subject legislation.

We also respectfully submit for your consideration our record for several years as a successful administrator of the "Dependents Medical Care Act", Public Law 569, 84th Congress, Chapter 374, 2nd Session, H.R. 9429, and the "Federal Employee Health Benefits Program" Public Law 86-382.

Under authority contained in joint resolutions passed by the State Hospital Association and the State Medical Association, in the spring of 1961, our Nebraska Blue Cross and Blue Shield Plans have accepted the responsibility for establishing utilization review committees in most of the larger hospitals in Nebraska.

Our interest in and experience with this prob-

lem is mentioned here only as an example of our sincere desire to employ the type of controls necessary in the health care field so well emphasized in Public Law 89-97. Copies of the minutes of the various organization to which these resolutions are contained are also enclosed.

The Board of Directors of Nebraska Medical Service in recognition of the responsibility which the Social Security Amendments of 1965 places upon you and your office in the selection of carriers, respectfully requests that Nebraska Medical Service have the opportunity to demonstrate its belief that implementation of this legislation can be successfully undertaken by an agency whose close relationship with the providers of care has been one of the most important factors in the success of the agency itself.

We have assigned to the National Association of Blue Shield Plans complete authority to commit Nebraska Medical Service to a carrier role should our petition be acceptable to you. Our interest is total and our cooperation will be complete.

This only brings to mind, gentlemen, that we we didn't want Medicare anymore than anyone else did and Blue Shield Plans have fought it all the way down to the wire, but we now have it, so we feel we should make the best of it.

And we see if Blue Shield Plans are designated as the carrier under Part "B" that we, as physicians, may have much more control, much more say-so in the administration of this Medicare program.

Otherwise this will be done by groups without any physician control, whatsoever.

I think most of you who have gone into this thing can easily see that we are facing the fact now that we're going to have greater government control, the greatest third party investigation of us, than we have ever had in the history of medicine.

They will investigate our fee schedules.

They will investigate the payments.

They will investigate these utilizations of this program and it's only as we see it, through Blue Shield, that we as doctors can maintain a sort of control over the practice of medicine under the Medicare Act.

PRESIDENT PASCHAL: Thank you, very much, Dr. Rogers.

We're grateful to you and your committee for the work that you've done.

You've heard his report and the two specific recommendations that he has made before you.

I would ask for your consideration of the first recommendation and for a discussion of that, in which he and his committee recommends to the Executive Council the authorization of an in-depth exploration by Blue Shield Plans of the prevailing fee concept.

Is there a motion that this recommendation be accepted?

DR. JOHN GLASSON: I move it be accepted.

DR. SHAFFNER: I second the motion.

PRESIDENT PASCHAL: Is there any discussion?

DR. JONES: Yes, sir.

With reference to the latter part of this, I raise no objection but I am going to object to this.

The prevailing fee concept as I understood at the meeting the other night, meant that this was going to be and I quote "in depth exploration"; that this means that this growing rate of charges in the State of North Carolina is going to be studied by an organization not under the complete control of the Medical Society.

I am not going to object to the second part, with reference to the designation of the fiscal intermediary, but I think that you should give good careful thought to the first part before you very quickly vote on it.

As I understand the bill, H.R. 89-97, reasonable is the wording in this bill.

Now, some survey is going to have to be made of going rates—if you want to use the term, prevailing charges—it is just semantics, but what is going to happen after this is simply that reasonable charges, as applied to Public Law 89-97, which incidentally has nowhere in it the word "Medicare"—it's actually health insurance for the aged—is going to mean the means of setting up what is a reasonable charge and the fees charged by the physicians in the State of North Carolina.

If this is done under the complete control of the Medical Society, then we have some opportunity to control this.

If it is done otherwise, it becomes public information and that's my objection.

DR. WILSON: Mr. President, may I suggest the National Blue Shield Plans representative is here and is willing to be heard this morning—Ned Parrish—and it might be a good time for him to be heard, even though briefly.

PRESIDENT PASCHAL: Thank you, Dr. Wilson.

Yes, we do have Mr. Parrish here and we'll be glad to give him the floor at this time.

MR. NED PARRISH: [Assistance Executive Vice President, National Association of Blue Shield Plans]: Thank you, Mr. President.

Dr. Jones thought and I obviously didn't make it clear in our meeting, that any survey of fees or charges made in the State of North Carolina, or anywhere else, would be under the complete control of the Medical Society.

If the Medical Society chose to use the Blue Shield mechanism to aid and assist in the collection of the that data, that was fine, but at no time and I again recall that I made the point repeatedly that without the complete understanding and cooperation of medicine, the prevailing fee concept could not and would not succeed.

So, if this is a concern, then I would suggest that the motion as read by Dr. Rogers be easily amended

to accommodate this because certainly this is the intent.

PRESIDENT PASCHAL: Thank you, very much, Mr. Parrish.

You'll heard these remarks concerning this problem. Is there further discussion?

DR. MURPHY: There's a question in my mind. How much experience Blue Shield has had in medical fees.

I'm sure you've had wide experience in surgical fees, but it has been almost non-existent in the medical part of our practice.

PRESIDENT PASCHAL: Mr. Parrish, would you care to remark about that?

MR. PARRISH: Well, insofar as it pertains to what our problem is here now, these two things are tied in together.

The prevailing fee idea and the use of Blue Shield as a mechanism as a carrier under the De-Bakey law—the prevailing fee concept is a concept which takes into consideration specialties whether we're talking about internists, radiologists or what.

The prevailing fee concept on a broadly stated position, briefly stated, is a plan which would pay in full the charges of approximately ninety per cent of physicians in a given area according to their own predetermined charges and that, as I say again, applies not only to surgical care but to every other branch of medicine.

And, from the subscriber, or from the patient's standpoint, it provides for the predictability of coverage which he seeks.

PRESIDENT PASCHAL: May I ask the question that under this proposal, is the plan flexible enough so that the prevailing fees, or the usual charges, in an urban area in contrast to a rural area where expenses are much less—where there is a marked difference in expenses—does this plan, is it flexible enough to make provision for that?

MR. PARRISH: Yes, it hinges on that philosophy which is a radical departure from the existing methods used by the Blue Shield Plans and other prepayment organizations that have established, for example, statewide, a fixed statewide schedule of fees which has the result of overpaying in some areas and under-paying in others.

By establishing your prevailing charges, the going charge in an area on a geographic basis, this does recognize then the higher cost in the urban area and the lower cost in the rural area.

SECRETARY STYRON: May I ask this question then—what flexibility is there for up-grading or down-grading charges in the event there's inflation or deflation?

To paraphrase your question, the physician asks, "Am I locked into a schedule which I predetermine and submit? If I am, for what period of time?"

The answer is "No, he's not locked in" but he has the ability to adjust his fees at any time.

The only question at that point is, the only requirement, if he does adjust his fees upward that he

does so for his entire practice, not just for Blue Shield or for the prevailing fee concept. He does this for his entire practice and for all of his patients.

Incidentally, this program is not theory and longer. It's effective in five states.

There would obviously have to be some reasonable time factor in which he would give the Plan notice of his intention to increase his fees.

That could be ninety days, three months, six months or whatever was determined as a reasonable period of time between the Medical Society and the Plan.

But, specifically, yes, he can adjust his fees and do so for a variety of reasons; either because of increased expenses, because his skills have improved, his length in practice and all the other reasons physicians do increase their charges.

DR. MURPHY: Do you imply then that each physician will have a contract with the Plan?

MR. PARRISH: Each physician will establish his own profile of fees, his individual profile of fees, not group them. He will now have as he now does, a participating physician's contract with the Plan in which this agreed upon and all the provisions of his contract group will be understood.

DR. MURPHY: And, when this plan is sold, it will be sold as a complete package and not just the surgical part?

MR. PARRISH: To all practical purposes, doctor, this plan is not going to be sold for some time to anyone other than major industry because of the obvious costs and broad nature of the program.

So far it is in effect in five areas for the motors industry—it's in effect for Chrysler; in Kentucky for Ford. It's about to be introduced into the steel industry.

These are the organizations who are buying this program and those are all extremely broad programs, broad based and high level programs of medical care.

Wherever this program has been introduced to medical societies, it has been overwhelmingly endorsed without dissension of any kind.

The Delaware State Medical Association enthusiastically adopted it.

This has been true in Kentucky and true everywhere we've had anything to do with this.

I think for good sound reasons, we're finally coming full circle. We're finally reaching a point where for years hospitals, or Blue Cross has paid hospitals the cost of doing business. Blue Shield has not.

Medical care has never been paid for on this basis and this is an entirely new concept which recognizes the fact.

PRESIDENT PASCHAL: Thank you, Mr. Parrish.

DR. ROGERS: Mr. President, I'd like to clarify this point to the Council that we are not recommending that the prevailing fee concept be adopted and established.

Our study was to the degree that we felt that this was important enough that we should know more and so our request to the Council is purely and simply to authorize an in-depth study so that we may know more about this thing, and that this is applicable in North Carolina, then we come back to the Council for further recommendation.

DR. BEDDINGFIELD: Dr. Rogers, there's a possibility after the study, that you could conceivably come up because of the complexion of North Carolina, that you would not recommend it?

DR. ROGERS: That's right. All we're asking for is the authorization to study this to see whether it is worthwhile.

In other words, we don't want to miss the boat if this thing is good for us.

DR. BEDDINGFIELD: In view of the fears that have been expressed about dissemination of the results of such a study for a given area, and Dr. Jones's fears of the lack of physician control, could the Medical Society undertake such a study, delegate it to the Blue Shield people, so the information could not be disseminated?

DR. ROGERS: As far as how the plan has been worked in other areas, the information which is obtained, insofar as for instance your prevailing fee for such-and-such, our procedure is entirely confidential, just as is what you put down as your charge for a procedure under any other plan.

That is confidential between you and the carrier and it is not a fact for publication.

I don't think there has been any indication or any implication at any time that there is any dissemination of this information of a particular fee profile as sent in by a physician.

In other words, you send in your fee profile and that's your business with the carrier to establish your own profile and that's it, because the man right next door to you may have an entirely different schedule and it is confidential.

DR. RAIFORD: I was just going to try to crystallize the two points which have given some source of confusion.

One, this is a pilot study for information only and it's not binding.

Two, this is and should be made clear and stated that this is not binding for this year or the years to come.

PRESIDENT PASCHAL: I think that's true and it's my further understanding that a review of these prevailing fees can be made and the individual physician is in a position to alter his charges by proper notification.

Is that not so?

DR. BENTON: To whom is this information in-depth going to?

Shield Committee and upon the results of this,

PRESIDENT PASCHAL: Primarily to the Blue they'll base their future recommendations.

DR. RAIFORD: Blue Shield Committee which is an arm of the Medical Society.

PRESIDENT PASCHAL: Is there further discussion?

DR. JOHN McCAIN: What would be the—say you had some information here about the rates in North Carolina and say California had accumulated a set of figures, and later in implementation of this program, would there be much difference, say, in pay schedules between the one in North Carolina and the one in California.

If we determine this information, would we be precommitting ourselves to a lesser schedule than what is paid in California?

PRESIDENT PASCHAL: I don't think so. I think that on the basis of the law itself that the usual and customary charges would come under consideration for any given area.

Are you ready for the question at this time?

All those in favor say "aye"; opposed by like sign.

DR. JONES: No.

PRESIDENT PASCHAL: The motion is carried with dissent.

Now, secondly, we have to consider the second resolution that was recommended by this committee to the effect that:

Be it,

RESOLVED, that the Blue Shield Committee of the Medical Society of the State of North Carolina recommend to and urge the Executive Council of the Society to recommend the two Blue Shield Plans of North Carolina as the joint carrier for administration of benefits under Part "B" of Public Law 89-97 and that the Council communicate the resolution under an appropriate carrying letter to the Department of Health, Education and Welfare.

What is your pleasure concerning this?

I might say we've had communications from Mr. Herndon of the Hospital Care Association and Mr. Crawford of Hospital Saving, to the effect that they are willing and interested in serving the Society in this capacity and assuming the responsibilities indicated in this resolution.

Not only have they indicated their interest, but a number of our members, who are members of the Board of Directors of these two organizations, have written urging the Council to endorse them as the carriers.

Is there a motion to the effect that this recommendation be accepted?

DR. RAIFORD: Mr. President, I think we all realize that this is not a political plum to be dropped in the laps of any receptive insurance carrier; that it is an obligation that they are willing to assume for the medical profession.

In view of this and the fact that we have had proper liaison and good rapport with the Blue Plans, especially Blue Shield, I would therefore move that we accept the recommendation of the Blue Shield Committee and that the President be directed to write a suitable letter stating our preference to HEW.

DR. KOONCE: I second the motion.

PRESIDENT PASCHAL: It has been moved and seconded. Is there further discussion concerning this motion?

If not, all in favor let it be known by saying "aye"; opposed by like sign.

It is passed and it will be so done.

(Dr. Rachel Davis was called on.)

DR. RACHEL DAVIS: To the Executive Council of the Medical Society of the State of North Carolina, I present this proposition.

It having been found that there are several areas of committee activity within the Medical Society of the State of North Carolina which have overlapping purposes, interest and responsibilities, it is felt that in order to aid the Medical Society of the State of North Carolina in fulfilling its purposes and more completely accomplishing its goals that the Medical Society of the State of North Carolina should recommend to the State Board of Health, or to the State Board of Mental Health, or to any other already legislatively established health agency that it give favorable consideration to the establishment of a new division tentatively called "The Division of Family Living".

Also, to request the chosen state agency to request budgetary increment for this purpose from the State Advisory Budget Commission and from the General Assembly to this end.

Below are listed the purposes for this proposition:

1. It will create a constancy of effort by an ever-present agent in a health facility in North Carolina in the area of family living.

2. It will be an avenue for correlation of efforts of many committees within the state who are involved in the areas of family living; many committees and agencies.

3. It will create within the state capital area an ever-present liaison committee to make more effective the efforts of the State Medical Society's committee on education, mental health, pre-marital education and counselling and juvenile delinquency.

In case of approval of the above proposition by the Executive Council of the State Medical Society, the Advisory Committee on Marriage Counselling accepts the responsibility to further research, study and crystallize the means for making this proposed program effective and to this end, will seek the help and cooperation of all involved State Medical Society committees and state committees and agencies.

tal health committee and the support of the school health committee and the maternal and child health

The above proposition was approved by the men-committees were committed by Dr. Thomas Thurston (Commissioner).

Respectfully submitted, Rachel Davis, Chairman.

PRESIDENT PASCHAL: Thank you, very much.

You've heard the recommendation of Dr. Davis's committee. What is your pleasure?

DR. McCAIN: I move its adoption.

PRESIDENT PASCHAL: Dr. McCain moves that this motion be adopted and the report be adopted.

Is there a second?

DR. DUCK: I second the motion.

PRESIDENT PASCHAL: Is there discussion?

DR. WILLIAMS: Mr. President, I would like to ask Dr. Davis a question.

Has there been any conversation with either the State Board of Health of Mental Health? Would they welcome this? Do they know about this?

DR. DAVIS: They both know about this. Dr. Norton was a member of the Committee who filed this proposition and Dr. Hargrove was kind enough to come into the meeting yesterday afternoon and due to Dr. Hargrove's interest, there was a change made in the original proposition.

It was to be given to the State Board of Health and a new department created in there, and the wording was changed from the State Board of Health to the "State Board of Health or the State Board of Mental Health or to any other already existively established health agency."

PRESIDENT PASCHAL: Dr. Norton, do you have any remarks concerning this?

DR. NORTON: No, I have not, except that I have the privilege of attending our discussions along with you at Dr. Rachel's hospitality at the meeting recently and I feel it will do a good job in pulling these various groups together.

In that way, I think it's a fine thing.

PRESIDENT PASCHAL: Is there further discussion?

DR. WILSON: The Commissioner wanted to say he's very much in favor of this, for what little good that might do.

DR. KERNODLE: Whose discretion will it be left to to decide which area this will go into—to make this either/or?

PRESIDENT PASCHAL: They're going to make a study investigate to determine what is the appropriate agency, and I believe that recommendation will come back to the Council.

If there's no further discussion, all in favor of this report and recommendation or motion, let it be known by saying "aye"; opposed by like sign.

That motion is carried.

Now we'll go to Item 7 and have a report on future meetings of the Medical Society (a) the Fall Conclave of Committees, and (b) Officers' Conference.

MR. BARNES: Well, this is just simply to report as commissioned by the Council the projected arrangements for the Fall meetings of the Conclave and for the mid-winter meetings of the officers' conference.

And, we have an effective reservation contract with Mid Pines for September 1966 and for September of 1967 for the Conclave.

We could not get back to the Pinehurst for either

of those two years.

Now for the Officers' Conference, we have contracted with Pinehurst for 1966 and 1967 for the dates given here.

Now, I would presume and I made a memorandum that the Council would continue its instruction to the headquarters office to seek immediately after this meeting a site for 1968 meetings—the two reported functions of the State Medical Society and without objection, the headquarters staff will proceed on that in the next two or three weeks.

PRESIDENT PASCHAL: If there is no objection, why, the headquarters staff is duly instructed to continue with this and this will be accepted now as information only.

Are there questions?

If not, it is accepted as information.

We go now to item 8 "Consider action on membership status of John H. Cox, M.D., Forsyth County-Guilford County and Mr. Barnes—"

MR. BARNES: As the Council may have recalled, this question of an application for membership by Dr. Cox a family physician residing in Guilford County who had established an office in Forsyth County and had applied for membership in Forsyth County, had been to the Council before and it was referred to the Council for further effort and action.

Now, after subsequent delays the Guilford County Medical Society has given its permission for Dr. Cox to have membership in the Forsyth County Medical Society since it is his intention to sell his house in Greensboro and move to Forsyth County.

Dr. Shaffner tells me today that it's just a question of re-referring the matter to the Board of Censors of the Forsyth County Society for action and we see no impediment to that.

If I may, I'll move on to the (b) section of the same Item 8.

I might say that we reported both these matters to the Executive Committee of the Council on the 26th of August and we were instructed that if the respective counties did give permission for these two men to be members of the county of their designated choice then the headquarters office would be authorized to go ahead and register them on that basis.

DR. WELTON: This concerns Dr. Jackson Vance Scott who resides in Mecklenburg County, who practices in Gaston County as an associate with Dr. Richard Rankin.

Dr. Scott applied to the State Society for membership in January 1963, via his membership in the Mecklenburg County Medical Society. He paid the full three-part dues to the Mecklenburg County Medical Society and apparently there was no definitive action about this during the subsequent year or two.

He still maintains offices and practices in Mount Holly and for these reasons Gaston County would like to insist on the continuing policy that phy-

sicians practicing medicine in this county maintain active membership in the Gaston County Medical Society.

His place of residence is in Mecklenburg County. Since AMA membership requires good standing in any county society, I think he makes this requirement.

DR. RAIFORD: Well, I think the motion previously was to the effect that the Council advise Gaston County and the counties involved and the applicant, the doctor, involved that he comes within the provisions of this section of the by-laws which permits him to belong to the Mecklenburg society and to transmit his application for membership in AMA.

DR. McCAIN: I second that.

(The motion carried.)

(The meeting recessed at one-three o'clock.)

SUNDAY AFTERNOON SESSION

September 26, 1965

The Fall Meeting of the Executive Council of the Medical Society of the State of North Carolina reconvened at two-twenty-one o'clock, President George W. Paschal, Jr., presiding.

PRESIDENT PASCHAL: We'll proceed now with the Thompson Report of August 1965 Revision from the Sub-committee on Mental Retardation and Children's Services.

DR. McCAIN: This is a report that was submitted to the Executive Council at the last meeting, and it was the recommendation of the Executive Council that it be sent back to committee and be studied with the various other committees concerned with children's services, and this was done in July.

A final revision that met the recommendations of all the various Medical Society committees reviewed it and it has been revised to the extent that they recommend it and it has been recirculated for review by the members of the Executive Council.

What this report does in general, is it serves to bring together the services for mentally ill children in North Carolina and not only promotes these services, but assures medical reorientation.

I would like to move the adoption of this report.

DR. KOONCE: I second it.

(The motion carried.)

DR. WELTON: The Committee on Hospital and Professional Relations recommends that Radiological billings for hospital patients be separated into technical and professional portions, not only to include those 65 and older, but for all patients in hospitals.

PRESIDENT PASCHAL: Gentlemen, you've heard this recommendation.

DR. WELTON: In my discussion with members of this group, they wanted the support of the Council and certainly the approval of the Council in the efforts that they're making in trying to have their proposal accomplished.

SECRETARY STYRON: I move that we go on

record of approving this recommendation.

DR. MURPHY: I second.

(The motion carried.)

MR. BARNES: Mr. President, as of July 28th, we received certification of the Avery County Medical Society signed by Dr. Vance, Secretary of that society, indicating that Dr. V. B. Rambo is at present employed by the Southern Presbyterian Mission Board and serving in the Congo, Africa area as a medical missionary and that they recommend him for consideration of Honorary Membership in the Medical Society of the State of North Carolina, for which there is a provision in the constitution and by-laws.

SECRETARY STYRON: The Executive Council had discussed this at some length at a previous meeting. This is in order and I therefore move that we nominate Dr. Rambo as an Honorary Member of the Society.

DR. MURPHY: I second.

(The motion carried.)

(The motion carried.)

DR. PASCHAL: As you were told earlier, Dr. Romm has replaced Dr. Brinn as Councilor for the 1st District. He was Vice Councilor and he has now been elevated to the position of Councilor for the 1st District.

MR. BARNES: The fact of his successor is a problem.

DR. ROMM: I propose that in the event I am unable to serve as Councilor of the 1st District that Dr. Ed Bond take over.

DR. KOONCE: I'll second that.

(The motion passed.)

DR. PASCHAL: Now, it is the intention to do the same thing for the 10th District.

So, in the event of a need for a Vice Councilor in the 10th District, is there a name suggested for a Vice Councilor?

DR. JAMES RAPER: I suggest the name of Dr. Ernest Stein.

PRESIDENT PASCHAL: You've heard the suggestion that Dr. Stein be Vice Councilor in the event of Dr. Raper's inability to serve as Councilor.

DR. RAIFORD: I'll second that motion.

(The motion carried.)

The Council then approved appointment of Dr. Robert Harper as Chairman of the Section on Neurology and Psychiatry and Dr. Lewis Rathburn Chairman the Section on Obstetrics and Gynecology.

DR. WELTON: Mr. President, I have the report from the Medical-Legal Committee which states that they have considered the request by the North Carolina Nurses Association for a joint liaison effort in developing a policy statement and legal protections relative to application of closed heart resuscitation by a nurse.

Part of the problem is that the nurse is an employee of the hospital and emergency room and if she's instructed to do something by a physician, or if she does it without the presence of a physician, is

she liable or is the hospital liable.

Noting that this subject is on the program of the American Heart Association meeting scheduled in Miami on October 11, 1965, the Committee Chairman will get in touch with the nurse association after that date and with the president of the North Carolina Hospital Association concerning a joint meeting on this subject.

PRESIDENT PASCHAL: This, I assume, will be accepted by the Council as information. (So moved and approved.)

Now, Item 16, Military Dependents Medical Care, Veterans Administration Affairs, Letter of Agreement and Fee Schedule negotiation.

DR. WILSON: The Committee unanimously recommended to the Executive Council that the Military Dependents Medical Care Program Contract for the period October 1st, 1965 to September 30, 1966 be renewed by the Medical Society.

(The motion was made, seconded, and passed.)

DR. WILSON: The Committee on Medical Care for Dependents of the Uniformed Services recommends to the Medical Society of the State of North Carolina that a diplomatic letter be written to the Director of Veterans Affairs, Winston-Salem, North Carolina, to the effect that the North Carolina State Medical Society does not wish at this time to enter into a contract, either written, verbal or implied with the Department of Veterans Affairs which would ask the doctors of North Carolina to accept any fee which is less than the fee which they usually charge a private patient.

PRESIDENT PASCHAL: Is there a motion that the headquarters staff and the President in particular write such a letter?

DR. RAPER: I so move.

DR. GLASSON: I second it.

(The motion passed.)

DR. WILSON: The first committee report I want to give is the Advisory to Auxiliary and Archives.

There was one point that they brought out which charges me with the responsibility of bringing it before this group.

They said that the Auxiliary was doing, as the Society had done, with regard to eligibility of membership, by means of by-law changes.

They said that it had to be recognized that there were greater difficulties in some geographic areas because memberships were smaller and private facilities were used for meetings that were social in part.

medical education.

They were discussing ways and means of pro-

The other part of that committee was the Archives of Medical Society History, as they review the work being done on the history of surgery and history of production costs, section reprints for contributors

They also had a number of questions about the number and size of the volumes to be produced, and who was going to foot the bill and things of that sort, and I'm sure that after consultations with

various foundations that we'll have more to say about that, subsequently.

Next one is AMA-ERF.

The Chairman reported to the committee that \$9,597 had been donated by North Carolina doctors in 1964 and the chairman wanted it brought out—he wanted to do something to increase this amount.

It was suggested that an AMA-ERF exhibit be gotten together and erected in the exhibit department at the annual meeting of the Medical Society in Asheville.

It was also suggested that an attempt be made to secure a film from the American Medical Association regarding AMA-ERF and show it at the Audio-Visual Section at the annual meeting.

It was also suggested that the membership in this committee be enlarged insofar as is possible, or rather the merits of enlarging the committee members was discussed, since the results of the committee activities depend greatly on personal contact and there was a need for representation in more areas of the state.

We didn't exactly know how to go about asking for a larger membership, but it did seem logical to suggest that when the new committees are appointed, next year, that we give favorable thought to enlarging this committee, in order that we might have better geographical representation.

Not in the sense of constitutionally changing anything, but that more members be put on that committee.

The next is Blue Shield, which was discussed at some length earlier this morning.

The next is Constitution and By-Laws by Dr. Shaffner.

DR. SHAFFNER: We voted to recommend a change for Mr. Hilliard from Assistant Executive Secretary to Assistant Executive Director.

The next thing we have requested is a detailed index of the constitution and by-laws.

Then we ask for some consideration of the tenure, and consideration of the committee structure.

DR. PASCHAL: I think it would be appropriate on the part of the Council to request that the Chairman of the Committee on Constitution and By-Laws communicate with the respective component societies and urge them to up-date their constitutions and by-laws and resubmit them to headquarters.

I would hope that you would also point out to those who have not complied with this request of rather long-standing agreement, should do so at once.

We had representatives from Bowman Gray, University of North Carolina and Duke. They gave extensive reports on what their chapters were planning and what they had accomplished in one thing or another they were undertaking.

DR. WILSON: Our next committee is Student AMA.

It was pointed out that a lot of them did not have access to the North Carolina Medical Journal.

Some of them had never seen a copy, so it was recommended that a certain number of complimentary copies be sent in some way or another to some of the medical students.

(A motion was made and approved to do so.)

DR. W. L. WILSON: The Governor, Governor Sanford, on December 31, 1964, designated the State Board of Health as the North Carolina agency for implementing a program of reviewing and counseling rejectees, who appear at Armed Forces examining stations and cannot pass the examination for any of the Services, or Forces.

Dr. Raiford wrote Dr. Jim Donnelly of the staff of the State Board of Health a two page letter giving his general reaction to the thing, but there have been quite a few developments since Dr. Raiford reviewed the matter.

I talked with Dr. Paschal and requested this privilege of bringing it to you now because of more recent developments.

The Congress appropriated funds for doing certain things with reference to these rejectees.

The funding is completely federal for what would be done under the act. The State would, through its one designated agency, undertake a prompt review of the reasons back of the rejection of each applicant for Service.

This would be done by a state agency director of programs who, in this instance, Dr. Norton designated me to be the physician since it is related considerably to some past experiences in the Army and, secondly, to pretty closely related to doctor-patient health as Dr. Beddingfield and Dr. Thurston confirmed.

The State Coordinator will receive the various individual reports on the rejectees. The Coordinator will direct the activities of the three law enforced examining station reviewers of the cases rejected; two at Charlotte and one at Raleigh examining stations.

The action from that point on is almost completely local; a community service at local level which we would hope local health departments would accept as a responsibility on a reimbursed fee basis, not to exceed \$10 per case for follow-up and to explain to the rejectee why he's rejected, to tell him what can be done, either in the realm of medical care, or surgery in certain instances, of vocational rehabilitation in some instances, and of course, in telling the rejectee that hasn't got any particular prospect, if he should be that particular unfortunate, that there's nothing that's going to be done by the community on his behalf.

North Carolina has approximately—to pin this down for you—approximately 8,000 rejectees a year at the present rate.

By 1970, according to the best estimates, the way things are going, that would almost double.

So, this is a significant matter, at least to certain families from the viewpoint of taxation and welfare and of other benefits, to the indigent who

is unable to help himself, to the unemployed.

DR. BENTON: What's the big thing? Because they didn't go through school?

DR. W. L. WILSON: About fifty per cent of them are not rehabilitable, but approximately 4,000 a year are and we can't answer your question directly, doctor, because until you have a program like this, all of it is purely mass statistics. There's nothing for the individual that one can single out.

A lot of administering arrangements would have to be made by the Medical Director of the Program with the Armed Forces examining station director, but we anticipate no problem. I know I can work that out all right.

PRESIDENT PASCHAL: I understood from earlier conferences that he would be referred to either his family physician, or to a local agency who is now normally taking care of people who are unable to pay.

DR. W. L. WILSON: Yes, that's right, but basically, what we would hope to do, in directing the program, is to work strictly through the medical profession.

Remember now, we have in the Medical Society a committee on occupational health and the local health director has begun to know about this and you work with him and vice-versa, so there is a reasonably easy channel for this.

(A motion was passed to endorse the program.)

(Dr. Paul Maness gave a brief report on plans for the Annual Session.)

DR. STYRON: Well, in essence, the Committee on Arrangements, under the Annual Convention Commission, wishes to come back to Pinehurst and this is the recommendation we make to the Society.

The dates of May 21st to 24th are the dates that we would recommend.

MR. BARNES: I report also that the hotel will be completely airconditioned in 1967. Mr. Smith tells me they have the installation already here. It's functioning here today.

It has the capacity for airconditioning all the rooms and all the rooms will be airconditioned by 1967.

SECRETARY STYRON: The question was asked if there is an earlier date and there is no earlier date.

The hotel is closed until the weekend before the one we have.

Mr. Chairman, I move that the Council accept one of these two dates, tentatively, one or the other and the Committee on Arrangements is to inform the Executive Council the preferable dates of May 14th to 17th or May 21st to 24th.

DR. KOONCE: I second the motion.

PRESIDENT PASCHAL: Any further question on this?

(The motion passed.)

DR. KERNODLE: I was handed a report from several committees under Dr. Lindsey's Commission and I'll try to extract from them the resolu-

tion that will be necessary.

The first Committee on Disaster Medical Care, a report was given on the past activities by our President, Dr. Paschal.

The new Chairman of the Committee is Dr. Anlyan.

Colonel Dawson gave a report on Civil Defense from his committee and distributed maps and charts on Public Fall Out Shelters in North Carolina.

The other thing is the Sixteenth National Conference on Disaster Medical Care is scheduled for October 30, and 31, 1965 in Chicago.

The North Carolina Eye Care and Eye Bank Committee maintains that the physician has every right to dispense eye glasses and contact lens to those patients who desire to be fitted by him.

We reaffirm the existing guidelines of the American Medical Association viz.:

One of the most important principles of the American Medical Association has been free choice of physician . . . This principle should apply to choice of optician . . ."

A patient is entitled to a copy of his or her prescription for glasses, drugs or applicanes and he has the privilege of having the prescription filled wherever he wishes.

We reaffirm our belief that:

Patients benefit immeasurably from the responsible physician's control over the quality and accuracy of dispensing as well as intelligent fitting services;

The prescribing physician has the sole responsibility for the patient's vision and comfort.

We propose the following specific guidelines for ethical dispensing of glasses and other visual aids by the physician:

1. The patient shall be given a copy of his or her prescription for glasses. This shall be given freely, willingly, and without embarrassment to the patient.

2. The patient has the privilege of having the prescription filled wherever he wishes.

3. The prescription blank shall not have the name of any optician or optical company printed upon it.

4. In dispensing glasses the physician must insure that the cost to the patient is fair and reasonable. The cost of the examination shall be listed separate from that for the glasses.

5. The quality of fitting and dispensing must be good.

6. Optical services shall be provided only to the patients of the doctor, except in the case of a true emergency where the service is not otherwise available.

7. There shall be no listing of dispensing by medical doctors in the yellow pages of the telephone directory.

The above represents an affirmation of existing practices by eye physicians of North Carolina and should be approved by the Executive Council.

DR. WILLIAMS: I move we endorse the guidelines as presented.

DR. JONES: I second.

PRESIDENT PASCHAL: All in favor let it be known by saying "aye"; opposed like sign.

It's carried.

Proceed, Dr. Kernodle.

DR. KERNODLE: The next report is from the Committee on Professional Insurances.

They held a meeting with representatives from the American Casualty Insurance Company, St. Paul Fire and Marine Insurance Company.

The Committee on Necrology recommends to the Executive Council the formation of a Memorial Service during the first meeting of the House of Delegates on Sunday, without an address or without the appropriate usual music, with opening invocation slanted toward the Memorial Service with a roll call of deceased member physicians.

A time allotted for this service would be approximately twenty minutes with a closing prayer.

It was suggested that the Auxiliary also hold their Memorial Services possibly at their House of Delegates meeting.

I mentioned this to one or two and asked for their reaction and the feeling was that this is a Memorial Service, and the ones I talked with at the House of Delegates said it's a business session and if it's going to be moved from a position it has had for so long, that probably it should come under the General Session.

When I discussed it personally with a few friends here, they said they didn't like to see the music go and the address taken away from this program. They thought it meant something to the relatives.

And, I just pass this on for what it's worth.

PRESIDENT PASCHAL: Well, let us take action on this at this time.

I attended the Necrology meeting and the Chairman wanted even longer than twenty minutes. It was thought by some who were there, that it could be done in ten with dignity and appropriateness.

This recommendation, I think, is an outgrowth of the very poor and meagre attendance at the last Memorial Service and some of the preceding ones.

It was their feeling that this could be done in the early part of the meeting, that it would take appropriate recognition of those who have passed on.

But, it's up to the Council for their deliberation and if the Council rejects it, the Committee on Necrology will be asked to continue as they have in the past and make arrangements for some Memorial Service, possibly on Sunday evening.

What is your pleasure?

DR. GLASSON: Mr. President, I might mention what's done in the Academy of Orthopedics. They have a Service of this type at the meeting that is attended by the largest number of official representatives at the meeting and this Service consists of a lantern slide picture of the deceased member, just one right after another, presented by the Chairman

of the Committee.

Then, they merely stand for a moment of silent prayer in memory of the deceased members.

It's dignified and everyone who has passed away is duly recognized by a large number of the members of the organization, which I understand is one of the short-comings of our past practice in this.

PRESIDENT PASCHAL: It was thought that at the meeting of the House of Delegates, they'd have good proportionate representation and more attendance, possibly, than they would have at any other time.

MR. BARNES: I might make this observation.

When I came to the Society, it was the custom to hold the Memorial Service during the course of the General Session, which in those days was the largest attended assembly of the State Medical Society.

Then there began to be some criticism of the amount of time they took up in the Memorial Service and they divided this Sunday Special Memorial Service with an address and appropriate music and that went on for a good many years with a fair amount of success.

DR. BRIDGER: I move the adoption of the recommendation as submitted.

DR. MURPHY: I second it.

PRESIDENT PASCHAL: It has been moved and seconded that we accept the report as submitted.

Is there further discussion?

DR. WILLIAMS: I'd like to make an amendment to your motion and second.

I'd like to make a substitute motion that this matter be left up to the Committee on Arrangements, if that's in order, with the idea that they can work out with the Necrology Committee a short but impressive program in a session where it would be better attended to answer the whole problem.

They're going to have to do in the final analysis anyway.

DR. KOONCE: I second the motion.

[Secretary Styron then made some remarks off the record.]

DR. BRIDGER: We'll vote on the substitute motion first?

DR. WILLIAMS: The other one is withdrawn.

DR. BRIDGER: Oh, it has been.

PRESIDENT PASCHAL: We will now vote on Dr. Williams' motion. Is that agreeable with the seconder of your motion?

DR. MURPHY: All right.

PRESIDENT PASCHAL: All in favor of Dr. Williams' motion let it be known by saying "aye"; opposed by like sign.

It's carried.

DR. KERNODLE: The Committee on Physicians on Nursing recommends there be a speaker at the next annual meeting and recommends one of the following: There's a doctor and three nurses: Hale, Sleeper, King and Smith.

It would be my recommendation that the Coun-

cil receive this as information.

PRESIDENT PASCHAL: You've heard the recommendation.

Is there a motion that that be so received?

DR. WILLIAMS: I so move.

DR. BRENTON: Seconded.

(The motion carried.)

DR. KERNODLE: The next report is from the Committee headed by Dr. Caldwell on Retirement Savings Plan and Trust agreement that was signed into activity on June 9th by President Dr. Paschal.

Wachovia Bank and Trust Company gave its approval and the Internal Revenue Service gave its approval.

Dr. Caldwell advised that he was contacting the presidents and secretaries of the county medical societies by letter and was inviting them to have a county society program on the North Carolina Medical Retirement Savings Plan sometime during the next three months.

PRESIDENT PASCHAL: Thank you, Dr. Kernodle.

Next, we pass on to Public Relations Commission; Dr. David Welton reporting.

DR. WELTON: There's one action requested by the Medical-Legal Committee.

They request that the Executive Council approve that the Committee undertake to develop a properly worded legal form relative to the certification of physical fitness of high school student participation on athletic teams.

Many of these forms are brought in, in front of you, in a hurry by the student or parent and it was the Committee's conclusion that they were all concocted by school authorities and they let the school off the hook so far as liability goes, but you may be subjecting yourself to considerable liability if you sign one without doing a thorough physical examination.

What the Committee wishes to do is—they've asked Mr. Barnes of the headquarters office to obtain a sample of a couple of dozen forms from schools around the state. They want to study these and then develop a form which they think is proper for physicians to use and then negotiate with the State Department of Public Education and Health for its statewide use.

Some action is requested on this.

PRESIDENT PASCHAL: Would you like to move that their request be granted?

DR. WELTON: As Councilor, I so move.

DR. RAIFORD: I second.

(The motion was carried.)

DR. WELTON: The next is Public Relations Committee which has rather a large budget. I think you would like just a quick review of what the program is.

They are continuing the exhibit at the North Carolina Fair next month, October 11 to 17.

They are continuing to support the high school science fair. This is an item of \$100 plus bringing

one of the winners to our annual convention at a cost of another \$100.

The "Today's Health" magazine awards have been sent as follows:

169 members of the North Carolina General Assembly; the Governor; the Council of State; the Supreme and Superior Court Judges and 56 North Carolina colleges.

Considerable discussion was given to this.

Mr. Hilliard made a survey of these colleges and within two weeks received replies from over fifty per cent of them, all of them appreciative, and it was voted to continue these items with this addition:

That the subscription going to each member of the General Assembly, there will be from the president of his county medical society a letter and a change in the card that goes with each subscription.

Then this letter is to be added to the kit that is put out at each officers' conference so that each president will have one to take home or to send to his legislative delegation.

Authorization of this Council is asked to proceed with developing a guidelines letter on procedure in handling grievances.

It appears that there are a good many members of the county societies, even some who attended our committee meetings, who do not know the proper procedure and a letter is to be developed by the Committee if you so approve, and put in the kit at the January officers' conference.

So, as Councilor, I move that this authorization be granted to the Public Relations Committee.

PRESIDENT PASCHAL: You've heard the motion.

Is there a second?

DR. RAIFORD: I second the motion.

PRESIDENT PASCHAL: Is there any discussion?

If not, all in favor let it be known by saying "aye" opposed by like sign.

Their request is granted.

DR. WELTON: Thank you.

The "Information Booklet for Physicians" starting out in practice for each new member of our society is currently being revised and will be reprinted.

Now, to give you a short run down on the program planned for the January Officers' Conference.

The Committee voted to continue the Friday evening function and to ask Dr. Paschal to be the host at the social hour.

And, then this evening is then devoted to instruction of the new county officers, particularly the presidents and secretaries, as to their official duties.

The Saturday program will include Leo Brown, Assistant to the Executive Vice President of the AMA and we've been fortunate enough to get Leo's consent to come down here.

And, he has been asked to speak on "Communications and the Physician".

Then, a program aimed specifically at informing

us so that we can then go back to the county society officers and inform the people in the communities about the chiropractic problem. Dr. Sabotier, one of the experts in the Louisiana program, will be invited to present this; a representative from H.E.W. who will be invited to speak on Medicare with panel discussion in which Leo Brown will be asked to participate and Ed Beddingfield.

And, Paul McCleave, former Chairman of the Society's Committee on Mental Health, Medicine and Religion, was invited and accepted.

We plan to use him as a luncheon speaker because the women plan to meet separately that morning, but will join us for luncheon.

One other talk is scheduled on the subject of "Ethics Today".

This is for information.

We have two questions which the Legislative Committee asked us to act on.

Number one: A mental health education proposal of a Health Affairs Exposition.

The Committee disapproved this as stated in the proposal.

Number two: Regarding a State Congress on Quackery for lay persons.

The Committee's statement is that they approve any means of dissemination of information as a method of exposing cults and quackery.

That is for information.

The next committee is Rural Health.

There is no official action requested. I would call your attention to the conference they have planned, an unusually good program to be held in Raleigh October 9th. If you have not seen this program, I'm sure Mr. Hilliard has some copies available.

There's a very useful list on the back of it.

I would like to have you reminded that National Rural Health Conference which is put on by the AMA will be held in Charlotte, March 10th and 11th, 1967, and our State Committee is taking action now to participate in the planning and implementation of that.

A staff group from AMA will visit Charlotte this March and make local arrangements, and this committee is going to contact them in advance and meet with them, and so on.

They had considerable discussion on the need for training of physicians as family physicians in general practice and it was the Chairman's request that our President be asked to ascertain from the deans of the three medical schools in the state what plans they have along this line.

I think that concludes that report.

The next is the Insurance Industry Liaison Committee which makes its recommendations to the Executive Council as follows:

The North Carolina Claim Review Service continues to function in its assignment of review of claims submitted to it as they concern health insurance.

The North Carolina Claim Review Service, as far

as is presently known, is the only committee of this type extant wherein the industry has agreed to review claims having to do with company practices.

Normally, claim review in the other committees of this type has to do only with cases submitted by the industry involving problems concerning professional services.

At their meeting on September 22nd, 1965 the Insurance Section of the Claim Review Service reviewed a non-industry submitted claim and voted unanimously that the claim, previously denied by the carrier, should be paid.

This apparently is quite unusual, to get an unanimous vote.

The Insurance Industry Liaison Committee recommends to the Executive Council that a Committee of the Society be assigned the responsibility of undertaking a study to ascertain what the range of professional fees and/or charges are for various services rendered by doctors of medicine in North Carolina.

If the Executive Council so chooses the Insurance Industry Liaison Committee would accept the responsibility for making such a study, provided that funds are made available for the necessary secretarial help or that such secretarial help is otherwise provided.

Such a study is recommended because of the obvious need for such information being available to this Committee in its deliberations in the field of health insurance.

Official action of the Council is requested on this recommendation and I so move.

DR. MURPHY: Second.

PRESIDENT PASCHAL: You've heard the motion and it has been duly seconded.

Any discussion?

DR. SHAFFNER: Question!

Would this overlap with this prevailing fee study that was brought up by Blue Shield Committee report?

DR. WELTON: I'll ask Dr. Jones to speak to that.

DR. JONES: It very definitely would overlap.

DR. SHAFFNER: Then, it would be a duplication of information, right?

DR. JONES: To answer your question, "Yes".

Mr. Chairman, I believe I might have something to say in connection with this at a later time.

Unless you intend to table action on this until the completion of the Commission Reports.

PRESIDENT PASCHAL: I would defer action on it until that time and we'll ask Dr. Welton to proceed.

DR. WELTON: As information, it is felt that as a result of the recommendations of the Health Insurance Advisory Board, the comb-1, which is a form for physician reporting of health insurance claims, will be designated by the Commissioner of Insurance as an approved form in and for the State of North Carolina.

Now, Mr. Hilliard has informed me that a mail-

ing of all of these forms will take place within the near future.

That completes that report.

The next report is from the Committee on Liaison with the North Carolina Pharmacy Association and there are eight items here I'm going to report for you.

The Committee's chief effort during the past year has been working with the State Welfare Department in developing the drug program of Kerr-Mills. This began functioning early this year.

Some problems, of course, have been encountered, one of them being what drugs can be dispensed directly to patients and which physicians would be granted permission for so doing.

The Committee plans to repeat an explanation of these drugs, legend drugs and non-legend drugs, to be sent to all members of the Society.

Then, they will get up a report of the first year's operation of this plan, probably early next year.

There will not be the joint Congress held this year with the pharmacists.

The Committee will prepare a statement jointly with the North Carolina Pharmacy Association calling attention to the uncontrolled filling of prescriptions by certain out-of-state organizations; one of them being, for example, the Association of Retired Persons which maintains a prescription pharmacy in Washington, D. C.

They will point out the dangers about lack of quality control, lack of refill control, etcetera.

Now, for Council action, the Committee presents a proposed inter-professional code for physicians and

The Committee requests your approval to submit this to the North Carolina Pharmacy Association for pharmacists, modeled after the Indiana Code.

their approval, with or without any changes that they want; then, report back to this Council at the January meeting.

As Commissioner, I move that the Committee be authorized to proceed in that manner.

PRESIDENT PASCHAL: All right.

Now, you've heard the motion.

Is there a second?

DR. BEDDINGFIELD: I second it.

PRESIDENT PASCHAL: Any discussion?

If not, all in favor of the motion let it be known by saying "aye"; opposed by like sign.

They are so authorized.

DR. WELTON: If you please, you may take this with you and if you want to make any changes, please mark them and please mail them to Dr. John Dees.

I wish to inform you about a newly formed—this has got more words in it than I've seen come out of Washington—"Advisory Commission of Plan of Assistance for the Development and Improvement of Pharmacy Service in North Carolina Hospitals" and the sponsoring organization is just about as long—by the North Carolina Hospital Education and Research Foundation.

They have a two year budget of \$48,000 which is being met by Duke Endowment, SKF and other foundations.

The background here is there are a number of hospitals which cannot obtain, or afford, a full-time pharmacist and they want to work out some plan of making part-time pharmaceutical supervision available to them.

The last problem they wanted brought to your attention is that they are encountering difficulties in getting VA prescriptions filled by mail. They send them to Winston-Salem and sometimes it takes two weeks and the Chairman of the Committee was authorized to invite Dr. Rose, the Regional Director, to attend the next meeting of the Liaison Committee.

That concludes the report of that Committee.

I believe our next Committee is the Liaison to North Carolina Department of Motor Vehicles report which meets four times a year, I believe.

The system of thirty physician consultants to the Department of Motor Vehicles continues to function effectively in reviewing the medical reports ordered by the Department.

These are not routine accidents. These are people who have been either cited for violations, or who have a medical problem that has been brought to their attention, of the Motor Vehicle Department.

The Committee considered certain changes in the question pertaining to eye examinations and approved those recommended by the Society's Committee on Eye Care.

been referred for review by the members of this consulting group.

Since May 1, 17964, a total of 1,805 cases have

They want to know what their findings, what their results are an where they're going and the dean of the School of Public Health at the University of North Carolina has agreed to supervise the statistical analysis of these and this is under way.

Next, we have the Committee of Association of Professions, which met last night after the social hour and dinner.

Dr. Kernodle's report is that the quarterly meeting of Association of Professions was held with Dr. W. Graham, Professor at the University of North Carolina, speaking on "The Independent Certified Public Accountant as a Profession."

This was followed by a business session at which time a resolution to endorse the \$300 mililon Road Bond issue was passed.

The decision was made to mail a flyer with endorsement to all members of the five professions who are members of this Association.

Upon conclusion of the quarterly meeting, the Committee of the Medical Sciety, met with seven in attendance and membership was the key issue. The decision was made for all members to present the program to their own local county societies and obtain membership enrollment.

This is to be followed through by Dr. G. H. Sat-

terfield who is Chairman of the Membership Committee.

We have one more report for you; that is the New Committee on Utilization.

For your information this new committee includes two members from the Blue Shield Committee; two members from our Insurance Industry Liaison Committee; two members from our Committee on Hospital and Professional Relations and three members-at-large, one of whom is Dr. H. Fleming Fuller, Chairman.

This was the initial meeting of this Committee which has been under consideration for some time.

The initial discussion centered on (1) need and justification for this committee and (2) approach to the problem.

Statements were heard from Doctors Paschal, Raiford, Jones and Raper and comments from representatives of Hospital Saving and Hospital Care Associations.

A full discussion was held and this plan of action was agreed upon:

1. Circularize all pertinent information to each member of this Committee, with a copy of the policy and statement suggested by Dr. Frank Jones. All of this material is to be studied by Committee members who will then meet again in the near future, within six weeks, with representatives of the State Board of Health and insurance carriers, invited to attend.

The objective of that meeting will be to develop a suggested statewide "Guidelines" for Hospital Utilization Committee duties and functions.

This would then be disseminated to the Chief of Staff of each hospital in North Carolina and to each county medical society.

The second objective at that meeting would be to develop and issue a broad statement of policy regarding the scope and functions of this State Utilization Committee.

Dr. Paschal was of the opinion that our component county societies and the members of hospital staffs are ready, willing and desirous of this help.

No official action is required on that.

I believe that concludes my report, Mr. President.

PRESIDENT PASCHAL: Thank you, Dr. Welton.

You've heard his report. Is there a move that it be accepted for information, excluding consideration of the problem that's raised by the Committee on Insurance Industry Liaison?

DR. WILLIAMS: So move.

DR. MURPHY: I second it.

PRESIDENT PASCHAL: Any discussion?

All in favor let it be known by saying "aye"; opposed by like sign.

Let me take this opportunity to say that it seems to me that the Committee on Utilization is one of extreme importance and it has some urgency to it.

And, it is my considered opinion that it would be very helpful if we asked the Chairman, Dr. Fuller,

to attend the meeting in Chicago and subsequent meetings that are coming up.

I would just like to have the authorization of the Council in having him attend these meetings.

DR. JONES: So moved.

DR. GLASSON: I second it.

PRESIDENT PASCHAL: All in favor let it be known by saying "aye"; opposed by like sign.

All right, so we'll do that.

Now, we'll go along to the Public Service Commission. I believe Dr. McCain is going to report for Dr. Thurston.

DR. McCAIN: The report from the Anesthesia Committee indicates he would like action on.

The Committee recommendation is that a procedure card could be made available to different areas in the hospital and that a cover outlining a simplified approach to the management of cardiac arrest be prepared.

This would be cleared with other committees that might be equally involved in this matter.

This would be a procedure card on cardiac arrest to be made available in these areas where it's likely to occur.

SECRETARY STYRON: George, this means if somebody is suddenly rendered unconscious, apparently from a heart attack, that they'll have some procedure to follow until they can get him to an emergency room, etcetera.

This is simply for information for people around the hospital.

DR. McCAIN: They might use the one from the Heart Association, mightn't they?

SECRETARY: Yes, they might.

DR. SHAFFNER: You want us to approve in principle their work on that?

PRESIDENT PASCHAL: Is that what they want?

DR. McCAIN: Right. I so move.

PRESIDENT PASCHAL: You've heard Dr. McCain's motion. Is there a second?

DR. GLASSON: Second.

PRESIDENT PASCHAL: Any discussion?

If not, all in favor let it be known by saying "aye"; opposed by like sign.

Proceed, Dr. McCain.

DR. McCAIN: Recommendations from the Committee Advisory to the Department of Public Welfare regarding the health matters will be deferred as of now.

The next report on the Cancer Committee, he has indicated he would like action on.

Recommendations for the Executive Council:

WHEREAS, The State Board of Health Cytology Lab cannot process anymore Pap smears due to the limited space and cytology technicians and.

WHEREAS, The physicians in North Carolina are sending Pap smears from private patients to the State lab, and,

WHEREAS, The pathologists of North Carolina have agreed to process all Pap smears locally,

Therefore, be it,

RESOLVED: The Cancer Committee recommends to the Executive Council that:

(1) There should be a gradual phase out of the Cytology Program in the State Lab beginning on the county level and to be extended over a period of a year or more; that the pilot phase of the project will start in the six county area around Goldsboro, North Carolina, with the cooperation of the local pathologists and the State Lab.

(2) That all positive smears which require a repeat smear requested by the State Lab will immediately be sent to the private pathologist in the local area.

(3) That the State Board of Health write a letter to every doctor sending smears to the State Lab stating that only indigent patients' smears should be sent to the State Lab and request that all physicians sending private patients' Pap smears to the lab and send them to the local pathologist.

The commentary he gave me on this is that the State Lab is becoming overwhelmed with these requests for smears, presumably on private patients.

That is sort of preserving the private practice, but he wanted us to write a letter to the State Board of Health to back them up to this effect.

DR. MURPHY: I so move.

DR. WILLIAMS: Second.

(The motion carried.)

DR. McCAIN: The next report is by the Committee on Chronic Illness.

They request authorization from the Executive Council to proceed with the planning and conducting of a workshop conference on Medicare in North Carolina.

This conference may be conducted jointly with the Governor's Coordinating Council on Aging or it may be the result of planning by the Committee in conjunction with interested federal and state agencies and private organizations.

The Chronic Illness Committee wishes to convey to the Executive Council that it looks with favor on the idea of the health affair.

I move that this be received as information.

The next report is from the Committee on Maternal Health.

A motion picture film called, "Nine Months to Get Ready" produced in North Carolina by the North Carolina State Health Department, was previewed by the Committee on Maternal Health.

The film was made as a training vehicle directed toward the education of young women of the "high risk" obstetrical group.

It is the intention of the State Health Department to show this film to lay groups, in high schools, colleges, civic groups, family life classes and where possible for presentation to television audiences.

The general reaction of the Maternal Health Committee to this film was highly favorable and they did resolve:

That this Committee on Maternal Health does endorse the training motion picture, "Nine Months to Get Ready", it being in good taste, highly professional in quality, educational, and well documented, and,

That this Committee recommends it for any lay or professional group interested in promoting prenatal care, and,

Encourage county health departments to obtain a copy of "Nine Months to Get Ready" for use in prenatal clinics and for showing on local television stations as a public service.

I see down the bottom here "endorsement" but without seeing the film, perhaps we could receive it as information.

PRESIDENT PASCHAL: All right.

We'll receive it as information with no action at this time.

DR. McCAIN: All right.

Now, from the Committee on Mental Health and Medicine and Religion, for action:

The Committee on Mental Health approves the Mental Health Law Brochure and recommends it to the Executive Council for its approval.

That has been distributed to the Executive Council in advance and it has been approved by the Attorney-General.

In general, the purpose of this brochure is an attempt to insure the rights of the patient, of his rights as an individual, and also an attempt to insure that the General Hospital take their proper role in treating these patients.

PRESIDENT PASHAL: Do you want to move?

DR. McCAIN: I move we adopt this approval.

(The motion carried.)

DR. McCAIN: The Committee recommends consideration be given to having medical meetings held at the State Hospital facilities with the thought of better orienting participants and giving participants a chance for questions and discussions.

This was in agreement with the State Department of Mental Health officials to be presented as information.

Another item of information, the Committee on Mental Health and Medicine and Religion presents the following resolution:

WHEREAS, the political leaders of the State of North Carolina carry a major responsibility in the health problems of the State; and,

WHEREAS, these political leaders deserve to be fully informed of the health problems of the individual citizens and the health plans and programs of all medical and para-medical organizations and agencies within the State; and,

WHEREAS, it is the responsibility of the Medical Society of the State of North Carolina to assist in what ever way possible the instruction of said leaders in these matters;

Now, therefore be it

RESOLVED, that the Medical Society of the State of North Carolina does hereby establish a Health

Affairs Exposition to be held in the City of Raleigh soon after the convening of the 1967 General Assembly;

And, be it further,

RESOLVED, that the specific purpose of this Exposition shall be the enlightenment of the members of the General Assembly on all matters affecting the health of the citizens of North Carolina and to outline advantages and disadvantages of any proposed federal or state programs concerning the health and welfare of our citizens, and

be it further,

RESOLVED, that the committee appointed by the President of the Medical Society should have the responsibility for this Exposition and is hereby authorized and directed to invite the participation of all appropriate agencies and private medical or para-medical groups, the requirements for participation being that the exhibiting organization, shall bear in full the cost of the exhibition plus its proportionate part of the rental costs of the Exposition site and that any controversial matter exhibited shall clearly define advantages and disadvantages of the proposal; and,

RESOLVED, that the Exposition shall first be opened exclusively to the members of the General Assembly at a time appropriate for their visiting and study and shall thereafter be open for a reasonable time to all citizens of the state.

This is a resolution presented for information.

We didn't feel that health, in general, has been given a fair shake by the law-making persons and law-making bodies, and this would be one way of presenting it to them.

This has been approved by a number of committees.

I see it was disapproved by the Public Relations Committee as stated earlier, so it has been changed to be presented to you for information.

If someone wants to pick it up and run with it, it would be fine. If they want to let it lie dormant, that's fine too, but it is presented to you for your information.

The Committee on Physicial Rehabilitation recommends the following:

The Committee unanimously recommended that centers for care of amputees be established in strategic areas in North Carolina, where none now exist, under the direction of a physician specially trained in the handling of amputees and attended by para-medical personnel, such as a physio-therapist, prosthetist, nurse, social workers and others. pist, nurse, social workers and others.

Directors and possible centers for amputees are suggested for Wilmington, Asheville, Kinston, and Raleigh.

DR. GLASSON: These are centers which are available in some areas, but there are large areas in the state which don't have such services readily available.

It's a support, a sort of a team approach to

prosthetics and I think it's the effort of this committee to provide this service more readily in areas which are listed specifically as medical centers
PRESIDENT PASCHAL: It has been moved that this be approved.

Is there a second to the motion?

SECRETARY STYRON: I second it.

(The motion carried.)

DR. McCAIN: The committee registered its protest to the action of the Vocational Rehabilitation and other agencies by crippled children for the blind at its inter-agency meeting to the assignment of different monetary values for medical services in different specialties.

For example, medical for surgery \$2.50; diagnostic radiology \$3.50 per unit.

The Vocational Rehabilitation Commission feels the monetary value or unit should be the same for all medical specialties and that if we and the Vocational Rehabilitation Division are going to adopt the Relative Value Scale a uniform co-efficient for each group should be adhered to.

That was recommended for your information.

PRESIDENT PASCHAL: Let's accept it as such.

DR. McCAIN: Another item to be received as information—

The Vocational Rehabilitation Committee feels very strongly about H.R. 8310 now before the House. It is known as the Vocational Rehabilitation Acts Amendment of 1965.

The Committee on Education and Labor made no amendments and recommended that the bill pass our committee in opposition to the entire amendments act, but feel most strongly opposed to the elimination of the financial needs requirements for the acceptance of Vocational Rehabilitation clients.

We recommend, therefore, that the means test be retained as a requirement for acceptance of Vocational Rehabilitation clients and that our delegates to the AMA meeting in Chicago urge at least this amendment to the act.

DR. BEDDINGFIELD: Dr. Walter Hunt brought this to our attention, that this legislation would remove from the vocational rehabilitation program any consideration of need of any person of whatever economic strata.

He recommended that vocational rehabilitation of these people and their training be paid for vocational rehabilitation regardless of financial need.

MR. BARNES: In that case, Dr. Beddingfield, he would put physical rehabilitation on the same basis as vocational, or education, rehabilitation, which has never been a requirement.

DR. McCAIN: Now, there is a recommendation from the Committee on School Health which is to be received as information.

(1) The Medical Society of the State of North Carolina is interested in the support of expanded School Health programs which incorporate proper safeguards and guidelines for the private physician.

However, before final acceptance of such a pro-

gram there should be a conference with representatives of the State Board of Health and of the Department of Public Welfare and the Department of Public Instruction to study and to plan the details of the expanded program.

(2) The School Health Committee recommends to the Executive Council that any medical aspect of Operation Headstart should follow the same standards and procedures that are worked out for the expanding school health program as mentioned above, pending completion of this expansion, medical examination and treatment of Operation Headstart applicants should be conducted by private physicians on a fee-for-services basis as determined by each involved medical society.

(3) The School Health Committee supports the that to comply with the State Law, alcohol education Sub-committee on Alcoholism that the Medical Society should recommend to the school administration should be included in the school curriculum by at least the Ninth Grade, and physicians should offer in assisting in preparation of this curriculum.

I move that this be received as information.

PRESIDENT PASCHAL: You've heard his report. We've taken action on the report that required action and it has been moved that we accept the rest of his report as information.

DR. WILLIAMS: Mr. Chairman, Miss Zeigler just called my attention to the fact that back up under Cancer and this Papanicolaou Smear thing, she feels that we may not have understood correctly.

What the Committee was trying to convey—I believe she was there at the meeting—and she tells me that it's her impression that all Pap smears will cease to go to the State Board of Health and I think some of us thought it was only the indigent private patients of the private physicians could be sent.

DR. McCAIN: There seems to be too much doubt about this thing. I think we ought to clarify this statement.

PRESIDENT PASCHAL: Well, it seems to me it ought to be clarified. We ought to find out the intent of the Department of Public Health.

I would think that they would continue this service.

DR. McCAIN: In view of the questions that have been raised, is there some way—I voted in favor of it. Can I say we'll consider it?

PRESIDENT PASCHAL: I would prefer to send it back to Committee for clarification.

MR. BARNES: It can then be brought back to the next meeting of the Executive Council for approval.

DR. McCAIN: I so move.

DR. WILLIAMS: I second that.

PRESIDENT PASCHAL: Is there discussion about that?

If not, all in favor let it be known by saying "aye"; opposed by like sign.

DR. McCAIN: This completes my report.

PRESIDENT PASCHAL: Thank you, very much.

Now, it's my understanding that we have no communications from the Committees on Grievances, Negotiations and Nominations at this time.

We do have the problem of deferred action on Item E (f) which has to do with the Insurance Industry Liaison pertaining to the recommendation of a survey which was deferred for further discussion.

I'll entertain discussion on this point at this time.

DR. JONES: First, I want to rise to a point of order and with all due respect to the chair and apologies because of the lateness of the hour.

This is in connection with a previous piece of transaction acted upon by this Society, earlier today.

It is my intent, to ask the President, through any parliamentary ruling he can, to call again to the attention of the Society of this Council a possible error in a wide open, carte blanche, approval of the proposal of the Committee which the Council moved earlier in connection with the report of the Blue Shield Committee.

If the Committee had not used the words, "survey in depth" and the implication of such in the prevailing fees in this state, I would not object and if the Blue Shield Committee had asked for a pilot program in Mecklenburg County, with reference to the feasibility for determination of a possible insurance program in a given area, then I would and could not object.

I am worried and concerned over the future use of this data.

I am not convinced that the Medical Society of the State of North Carolina has any realistic control of any Blue Shield, Blue Cross organization.

Unless there is any member of this organization who knows the details of the early determination of Blue Cross for instance; unless control is obtained of the Blue Cross organization officers, other than the membership on the Boards of Directors of these two associations, I therefore propose to ask for a ruling in the province of action taken in Part I on a resolution presented by the Blue Shield Committee.

Is the Council bound by the by-laws of the State Society under Chapter 10, Section 14, regarding a Committee to review resolutions.

I ask this right after reference to Robert's Rules of Order regarding incidental motions, Article IV.

In taking this means, I wish to repeat that I have a great respect for both the Blue Cross and Blue Shield organizations in North Carolina and in no way do I wish to make it appear that I am, in the slightest manner, or in any way antagonistic to them.

PRESIDENT PASCHAL: You've heard Dr. Jones request.

Action was duly taken on this resolution this morning and in order to clarify this, we're talking about the resolution as proposed by the Blue Shield Committee that had to do with the survey in depth

of the prevailing fees, as I understand it, in a limited area in North Carolina, for the purpose of obtaining information.

Is it your purpose to have that action rescinded?

DR. JONES: It is my purpose, if it was not parliamentary, that this Council did act on a resolution without referring such to a Committee on Resolutions, in accordance with the by-laws of the State Society.

DR. GLASSON: Mr. Chairman, by way of clarification, this was a vote to authorize the study of this proposal.

It did not authorize the Blues to go ahead with this survey.

Did I understand this correct?

PRESIDENT PASCHAL: That was my understanding.

DR. WELTON: We authorized them to go ahead and do it.

DR. GLASSON: Ed. Beddingfield questioned if I remember correctly, the fact that this committee might come up conceivably with the answer that we not do this and indicating—we didn't vote to do it—but we voted to consider, for the committee to consider, whether we're going to do it or not.

PRESIDENT PASCHAL: That was my understanding.

DR. BEDDINGFIELD: We delegated authority to the Blue Shield Committee. They have the responsibility so it's a Medical Society study.

If they want to use Blue Shield personnel in conducting this study, in their data processing, and report to the Blue Shield Committee, they might. In fact that was the obvious intent.

DR. MURPHY: We didn't give them any money to do it with.

PRESIDENT PASCHAL: No.

DR. WILLIAMS: Mr. President, it would take a motion to re-open this by a two-thirds majority vote according to Robert's Rules to reconsider.

I would like to make such a motion, if it's in order.

DR. JONES: I shall say that I have tried to do what I can in this area because I'm frightened of it.

I've asked for a motion to reconsider. I can't make such a motion. I voted against it.

DR. SHAFFNER: I move we reconsider the question. I voted for it this morning.

DR. MURPHY: I'll second it.

PRESIDENT PASCHAL: It does require a two-thirds majority.

DR. SHAFFNER: That's debatable isn't it?

PRESIDENT PASCHAL: Yes, it can be discussed.

DR. MURPHY: We have a proposal to review the fees in this state from two different groups. The question comes up now which group would we rather have do it.

PRESIDENT PASCHAL: You've heard the question to reconsider and it has been properly seconded.

DR. KOONCE: Do we have a quorum?

SECRETARY STYRON: Twelve is two-thirds.

Now, the point I raise is this; whether it requires

two-thirds of those who are now here, or whether it requires the vote of everybody here to reconsider.

Does it require two-thirds of the original vote?

MR. ANDERSON: It requires a majority vote, of those voting.

PRESIDENT PASCHAL: We have a quorum and a majority vote will carry the motion.

The vote is nine to three.

All right, the motion is carried.

PRESIDENT PASCHAL: We are considering the motion that was made this morning that had to do with the prevailing fees in-depth survey.

Following presentations by the National Association of Blue Shield Plans concerning the prevailing fee concept of allowances for professional services, the Blue Shield Committee by motion and unanimous vote recommends to the Executive Council the authorization of an in-depth exploration by the Blue Shield Plans of the prevailing fee concept.

This involves determining individual physician charges for services to usual private patients.

The Committee assumes that the exploration will be on a pilot basis in a limited geographic area and will be done with the full cooperation of the county medical groups in the areas involved.

This is the motion that is being reconsidered.

DR. WELTON: Mr. President, I would like to suggest —That the Blue Shield groups be asked to present to the Executive Committee of this Council to present a detailed plan for this exploration in-depth before they proceed with same.

DR. BEDDINGFIELD: Mr. President, I do not think the two Blue Shield Plans should be authorized to do this. I think the Blue Shield Committee of the Society should be authorized to do this.

PRESIDENT PASCHAL: This says the authorization of an in-depth exploration by the Blue Shield Plans of the prevailing fee concept.

It goes on to say that this will be done with the full cooperation of the county and local medical groups in the areas involved.

DR. WELTON: I think it might get us in difficulty with the local and county societies if they were approached with a plan which the Executive Committee of this group had not approved, without knowing the details.

DR. MURPHY: Is it proper at this time for the other group who wishes to explore this, for them to present their views?

PRESIDENT PASCHAL: This would be appropriate in in the discussion that will follow, if they would care to.

DR. JONES: Mr. President, the Committee on Insurance Industry is not begging for this job.

The Committee on Insurance Industry realizes however the very marked necessity for some decision, some plan, some effort to be made in connection with a determination of what we like to call "going rates".

In the Committee, the discussion was largely with reference to HIFA, which is our name for Health In-

surance For the Aged.

However, in the formulation of the request and recommendation to the Executive Council, we very carefully avoided any connection with the Health Insurance for the Aged.

DR. BEDDINGFIELD: I'd like to ask Dr. Jones a question.

If the Insurance Industry Liaison Committee is authorized to carry out the study that they contemplate, would it be done on an area basis as the Blue Shield intends to do it, or would it be done on a random sample?

DR. JONES: It would be done on an area random sampling.

Say for instance, there would be a questionnaire go out, presumably with the approval of the Society, saying we need these figures.

Then there would be the replies that come in which would not be signed, but they would be categorized in the essence that we would know whether they came in from Asheville. In other words, we would know if it came from a man from Asheville; whether he was in general practice, if he was a radiologist and what type of practice he was in.

It's going to take some money to do it and that's one thing I want you to consider because it's going to be expensive.

PRESIDENT PASCHAL: Dr. Jones, can I ask a question for my own information?

Would the information that your survey would gain be any different from what would be gained by the one that has been proposed by the Blues?

DR. JONES: I don't think the information will be any different.

PRESIDENT PASCHAL: It is my understanding that this information that is obtained under the provision of the motion that was made this morning, is privileged information to be shared by the Blue Shield Committee and by the Medical Society and it would be on the basis of this limited geographic study that conclusions would be drawn.

Is there other discussion?

DR. GARRARD: Blue Shield, Blue Cross forms in the last few months that I've seen, each one asks you what your customary fee is and I've been signing these for months.

They know what my customary fee is, so that they can use the information officially. They've already got the figures, so that they could extract the information from the claims in the past twelve months.

DR. JONES: May I say what this group wants?

Having been in this work for a long time, they want to market a new plan. They want to market a plan which might be to our advantage as physicians.

You, Dr. Paschal, and several other member of this group were at that meeting, at which they were presuming a new plan which would pay a doctor according to his rates that he charged, his prevailing fee, up to a certain point and then beyond that, throw it out the window.

In other words, if it was ten per cent above, they

couldn't pay their rates. It would be too high.

If the motion simply that they would go into Mecklenburg County with the approval of the Mecklenburg society group with the idea of marketing a program, I couldn't have possibly objected to it, but we would still have to have a statewide survey.

PRESIDENT PASCHAL: I think it was the feeling of the Blue Shield Committee that the local geographical survey would afford them information that would be very helpful in developing and eventually implementing such a plan.

I think the Blue Shield Committee made this motion, or made this recommendation, because of the facilities of the Blue Shield Plans have for expediting such a survey and for correlation of any data that may be obtained, but it's still—

DR. McCAIN: Why not refer this question back to these two committees, have them make a recommendation and come back to the meeting of the Executive Council and defer further action on it for now?

Is there any urgency about this survey?

PRESIDENT PASCHAL: I think it was felt to be urgent in that some planning ought to be made possibly before January.

SECRETARY STYRON: I believe you are confusing two items. You are not talking about Item 2.

You are talking about the survey only. You're not talking about the use of Blue Shield Plans as a carrier. That was accepted and that's not apropos to this discussion.

Now, the first part, as you may remember, Ned said that they had no idea in the near future of introducing this plan. It might be a matter of three years.

So, there is no urgency about this particular matter.

There was urgency about the other part which was passed and which is not under discussion now.

DR. JONES: The record will show I supported verbally on the floor the endorsement of the Blue Plans as the fiscal intermediary.

PRESIDENT PASCHAL: That's true.

DR. McCAIN: About this whole question on which there is so much controversy, maybe having these two committees work on it and make a recommendation at the next Executive Council for consideration of the whole thing?

That's just a suggestion.

Do you wish to make a motion?

DR. McCAIN: Yes, I wish to make a substitute motion that the Blue Shield Committee and the Insurance Industry Liaison Committee—have these two meet together and consider it and make a recommendation back to us at the next Executive Council meeting.

PRESIDENT PASCHAL: Such a motion is in order.

DR. JONES: May I ask one thing? That only those committee members attend, except for Medical Society headquarters personnel?

Would you accept that?

DR. McCAIN: Well, how about letting the vote be taken in the absence of the other persons? Let the other persons present their material and then have the vote taken in their absence. That would give them an opportunity of presenting their material.

DR. JONES: Yes, all right.

PRESIDENT PASCHAL: You've heard Dr. McCain's motion.

Is there a second to it?

DR. WELTON: I second it.

PRESIDENT PASCHAL: It has been moved and seconded.

Now, this is a substitute motion to the one that was made and passed this morning.

All those in favor say "aye"; opposed by like sign.

The motion is carried without dissent.

We come to Unfinished Business! [No response.]

Is there any Old Business to be considered? [No response.]

Any New Business to be considered?

MR. BARNES: I just wonder if the actions of the Executive Committee of the Executive Council at the meeting on August 26th and referred to the Council as information need to be recognized into the record.

That is a schedule of seven items submitted for information only and then a second schedule of six items, information and report of actions of the Executive Committee.

DR. BRIDGER: I make a motion that they be put into the record, as printed.

PRESIDENT PASCHAL: You have heard the motion that they be incorporated into the record. Is there a second?

DR. WELTON: I second it.

(The motion carried.)

DR. BEDDINGFIELD: The Governor has appointed Bob Howerson, an attorney, as Chairman of the Board of Public Welfare.

Mr. Howerson is an attorney for the Dental Society and helps them with their health matters and a professional neighbor of Mr. Anderson's.

And, we hope we can work closely with him on problems that involve public welfare.

PRESIDENT PASCHAL: Thank you, Dr. Beddingfield

I want to thank all of you for your sustained interest and help here.

[The meeting adjourned at five-fifty-two o'clock.]

SUNDAY MORNING SESSION

November 21, 1965

The Special Called Meeting of the Executive Council of the Medical Society of the State of North Carolina convened at eleven-six o'clock in the King William and Queen Mary Room at the Velvet Cloak Motor Hotel, Raleigh, North Carolina, Dr. George W. Paschal, Jr., President of the Society, presiding.

(Dr. Charles W. Styron, Secretary of the Society, called the roll.)

**MEDICAL SOCIETY OF THE
STATE OF NORTH CAROLINA**

BUDGET ESTIMATES

January 1, 1966 to December 31, 1966

RECEIPTS: (ESTIMATED)	\$280,017
Estimated balance January 1, 1955	Nil
Assessment 3150 paying members*	220,500
Sales (estimated on 1965)	1,800
Author Contributions to Cuts	200
Revenue Unexpected (estimated)	600
Technical Exhibits (estimated)	17,000
Journal Net Advertisement (estimated Local on 1965)	8,500
Journal Net Advertisement (estimated National on 1965)	27,000
**AMA Remittance 1% of dues processed (estimated on 1965)	1,417
Annual Banquet Revenue (500 at \$6.00 each)	3,000
	<u>265,083</u>

EXPENDITURES: (Estimated)	
Schedule A	120,777
Schedule B	62,510
Schedule C	24,656
Schedule D	6,285
Schedule E	14,000
Schedule F	20,155
Schedule G	16,700
EXCESS OF RECEIPTS OVER EXPENDITURES	14,934

EXCESS OF EXPENDITURES OVER RECEIPTS	—
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RESERVES: (Costs, 26,104.55—Land)
 \$156,543.41 for 12,453.732 Shares
SUBMITTED TO COMMITTEE ON FINANCE—
 September 19, 1965
SUBMITTED TO EXECUTIVE COUNCIL FOR
APPROVAL—September 26, 1965
SUBMITTED TO HOUSE OF DELEGATES FOR
APPROVAL—May 2, 1966

*Based on dues at \$70 per member per annum
 **To be appropriated to Secretarial Budget A-6

A. EXECUTIVE BUDGET	120,777
A-1 President, expense of (travel & communications)	4,500
A-3 Secretary, travel of	1,000
A-4 Executive Director-Treasurer salary of	18,000
A-5 Executive Director, Treasurer travel of*	5,000
A-6 Executive Office, Secretarial & Clerical Assistants**	33,223
A-7 Executive Office, equipment for and-or replacements	6,600
A-8 Executive Office, expense of (12 months rent, communications, printing, and supplies, repairs and replacements of expend- ables)	13,000
A-9 Bonding (in effect to 1966)	915
A-10 Audit (Quarterly and Annual)	700

A-11 Taxes (salary tax)	2,593
A-12 Insurance fire, compensation and employer's liab.	251
A-13 Membership Record System (addition to)	100
A-14 Publications, reports and executive aids	200
A-15 Insurable: Interest insurance and retirement plans	5,295
A-16 Assistant Exec. Director, salary of	12,000
A-17 Rural Health Consultant, salary of	6,000
A-18 Assistants Executive Director, travel of	2,400
A-19 Rural Health Consultant, travel of	2,000
A-20 Assistants to Executive Director	5,000
A-21 Assistants to Executive Director, travel of	2,000

*Basis: Real for personal maintenance and travel at
 7c per mile and-or common carrier rate and for offi-
 cial purposes.

**Any revenue derived from collection efforts related
 to American Medical Association dues and processing
 of same shall accrue to this item of the Budget.

B. JOURNAL BUDGET	62,510
B-1 Journal, publications	38,000
B-2 Journal, cuts for	400
B-3 Editor, salary of	2,310
B-4 Assistant Editor, salary	4,800
B-5 Editorial Office, expense of (12 months rent, communications, printing and supplies, repairs and replacements)	450
B-6 Journal Business Managers Office, cations, printing and supplies, expense of (12 months communi- replacements and replacements)	450
B-7 Business Manager's Office, equipment for	100
B-8 Journal, travel for (local and national)	200
B-9 Taxes (salary tax)	300
B-10 Sales tax on Journal subscriptions and Roster sales	500
B-11 Roster, publication	5,000
B-12 Executive Council reports, Trans- actions, Annual Reports printing of	10,000

C. INTRA-FUNCTIONAL ACTIVITY BUDGET	24,656
C-1 Executive Council expense of and travel of Councilors including district travel	2,500
C-3 Legislative Com., expense of (local and National activity)	5,000
C-4 Maternal Health Com., expense of (secretarial Communications, printing and supplies)	3,600
C-7 Scientific Exhibits Com, and Audio-Visual Program expense of	675
C-8 Com. on Mental Health Medicine & Religion	500
C-9 Committee on Grievances	200

C-10 Committee on Chronic Illness	2,000	and transportation of	650
C-11 Committees in general, expense of	2,500	E-15 Annual Officers Conference	1,000
C-13 Committee on Occupational Health	200	E-16 Physicians Press Award	NIL
C-17 Committee on Student AMA (Section & Transportation & Delegate to SAMA one each Medical School Chapter (3))	1,931	E-17 Public and personified activities in the field of Public Relations	600
C-18 Committee on Disaster Medical Care	500	E-18 Collateral Public Relations with other committee activities	500
C-19 Committee on Industrial Commission	250	F. ANNUAL SESSIONS (112th) CONVENTION BUDGET	
C-21 Committee on Medical-Legal	100		20,155
C-22 Committee Advisory to N. C. Highway Patrol on Traffic Safety	100	F-1 Programs, Production of	1,750
C-23 Committee on Venereal Disease	150	F-2 Hotel and Auditorium expense	2,500
C-24 Committee on Anesthesia Study Committee	400	F-3 Publicity promotion, expense of (reporters and expense)	500
C-25 Committee on Blue Shield	500	F-4 Entertainment (general involving personnel)	900
C-27 Committee on School Health	400	F-5 Orchestra and floor entertainment	2,000
C-28 Committee Advisory to N. C. Board of Public Welfare	100	F-6 Guest Speakers (5) expense of and-or for honorarium for	1,000
C-30 Committee on Liaison to Insurance Industry	500	F-7 Banquet Speaker, fee and expense	300
C-31 Rural Health Function (Stationary) \$200; Sponsorship of 4-H Health activity for one trip to National 4-H Club for State Health Winner, \$500, & Dues Rural Health Safety Council, \$100; Rural Health Conference \$200	1,000	F-8 Electric Amplification, operators, installations and screening auditorium	125
C-32 Committee on Relative Value Schedule	1,300	F-9 Booth installations, supplies, expense, signs, (Scientific and Technical) including exhibit expense & promotion	4,000
C-33 Committee Liaison to N. C. Pharmacy Association	nil	F-10 Projection, expense of (service rentals)	700
C-34 Committee on Scientific Works	150	F-11 Badges (members, guest, exhibitors auxiliary)	150
C-35 Committee on Headquarters Facility	100	F-12 Reporting Service for Transactions (session & sections 13)	1,300
D. EXTRA FUNCTIONAL ACTIVITIES BUDGET	6,235	F-13 Rental, extra facilities, trucks for sections and-or exhibits	250
D-1 Delegates to AMA, expense of (4 to each annual and clinical session)	3,285	F-14 Exhibitors entertainment (at 5% of Exhibit Income)	1,400
D-2 Conference dues	200	F-15 Banquet expense and places for members remitted	3,000
D-3 Womans Auxiliary (contributions to entertainment, travel to National Auxiliary for 2 and productions; History factor \$600.00)	2,800	F-16 Police Security	280
E. PUBLIC RELATIONS BUDGET	14,000	G. MISCELLANEOUS BUDGET	16,700
E-3 Committee, Chairman, out of State travel	500	G-1 Legal Counsel, retainer fees for	7,000
E-5 Public Relations Equipment for,	1,250	G-2 Reporting (Executive Council, etc.)	1,700
E-6 Public Relations Office, expense of (12 months rent, communications, printing and supplies, repairs and replacements)	5,000	G-3 Fifty Year Club pins and certificates, and Presidents Jewel	100
E-8 Publications and Executive Aids	100	G-4 Contingency and emergency	1,500
E-12 Public Relations Bulletin, production and printing of	2,700	G-5 Retirement system for Society employees	4,900
E-13 State High School Science Fair Program, expense of	200	G-6 Advalorem Taxes	325
E-14 Exhibits and Displays: Purchase, rental, production, fabrication		G-7 Association of Professions Loan	350
		G-9 AAMC (Association of American Medical Colleges	225
		G-10 Commissioners, expense of	600
		E-9 Audio-Visual depiction; photography, radio-motion picture, production, distribution and printing, purchase of films, etc.	300
		E-10 Educational distribution; reports, periodicals, press materials, pamphlets and dodgers for educational purposes; production, distribution and printing, binding, stuffing and mailing	800
		E-11 News and press releases, production and printing of	400

SECRETARY STYRON: Mr. President, a quorum is present.

PRESIDENT PASCHAL: A quorum is declared.

This is an official meeting of the Executive Council called under the provisions of the Constitution and By-Laws and we have three things to discuss today, and only three things to discuss.

The first item four on this agenda has to do with the Blue Shield survey of prevailing medical charges.

We'll consider this matter at this time.

I think all of you are familiar with the chain of events which led to making this meeting necessary..

At the last meeting of the Executive Council, you will recall that an action was taken concerning making an in-depth survey in certain geographic areas of the prevailing fees in North Carolina and that was to be done by the Blue Shield groups under the supervision and direction of the Executive Council.

Later in the day, the motion was made to reconsider the action taken in the morning and the outgrowth of that was the motion which was made and passed that the two committees concerned, primarily the Blue Shield Committee and the Insurance Industry Liaison Committee, hold a joint meeting as early as feasible and try to resolve the apparent differences of attitude that were present.

This meeting was held and information concerning it has been disseminated to each member of the Council.

You have also been furnished with a copy of the joint resolution which was submitted.

Now, I think it would be appropriate here at this time, before we have a motion put on the floor of any kind, to ask the chairman of the two committees who were considering this matter to make a statement if they so desire.

DR. MAX P. ROGERS: Mr. President, first of all, I want to express my sincere appreciation for your calling this meeting concerning a problem which is facing us at the present time in looking forward to the activation of P.L. 89-97 in the summer of next year.

I think that by far, we must say this is going to have the greatest effect on medicine than any law that has been passed in the history of our nation.

If we are to save any sort of control over medicine in the future, we must get behind this thing and become active participants.

To those who know far more about this than I do, it seems that the prevailing fee concept nearly more approaches the idea than any other plan which has been put forward.

All the information that we could get together has been disseminated to your Blue Shield Committee as a matter of education, so that the Blue Shield Committee may be as well informed as possible on this subject.

We have studied the results of plans of other areas where the prevailing fee concept is now at work and I'm happy to say there are already fourteen other plans over the nation that are developing the prevailing fee concept.

An explanation, let me say again, of a prevailing fee concept is that plan of prepayment insurance where-

by the physicians themselves establish their own fees, or shall we say the fees that are paid are established by ninety per cent of the physicians in particular area.

This concept was developed by Blue Shield in answer to Labor who was demanding a prepayment, paid in full, plan.

All fee schedules as would be developed under the prevailing fee concept would be confidential.

Our knowledge and our schedules, of course, therefore are the property of the Medical Society and the physicians in the State.

The Council has the right, legally, to have any committee participate with us or cause us to give our information to any other committee of the Medical Society as long as it is in the best interest of the practice of medicine in this State.

We, in the Blue Shield Committee, are strongly convinced that we must get this thing underway and very rapidly.

mittee feel that our work, at the present time, is to

In summation of this, we in the Blue Shield Committee feel for the continued participation of physicians, to obtain as much control over the Health Insurance Act as we possibly can.

We didn't want this Act. We fought against it—all of us did, but we have it. We must now make the best of it and the best that we can do is by active participation, get the Blue Plans of North Carolina to be appointed as carrier for Pat "B", where this Council of the Medical Society and your Blue Shield Committee can control our fees, our utilization and act as an intermediary between the government and the physicians of North Carolina.

DR. FRANK W. JONES: As each of you must be aware, I am and was quite concerned over the impact of any type of prevailing fee study done on the economics of the individual physician.

Secondly, I was concerned over the power that rest with any organization doing the prevailing fee study and the availability to them to schedule fees which might not be, in essence, available to the professor, in general.

There are three possible means of doing the survey. This is by means totally outside of the Society, means to tally outside the Blue Plans, but like anyone else who hires an attorney, or physician, presumably, the data is confidential to the purchaser.

First is a Key Punch Verifier, which is the most expensive.

The second is a tape conversion.

And, the third is the censor.

The cost of Scheme one that is the Key Punch Verifier to the Society would amount to about \$5500.

From the Service Bureau Corporation, I have since contracted them—they say that even with a 1200 item survey, it would be done for about \$10,000 by an outside agency, or less.

I would call to your attention a question that comes up, "Would a survey done by the Society be acceptable to the Department of Health, Education and Welfare?"

Frankly, I don't know whether it wouldn't be.

I know that in many areas the Blue Shield organization are under much greater control by the Medical Society than they are in the State of North Carolina.

There has been a definition of reasonable fees which says in essence as follows:

A usual fee is one that is ordinarily charged by the Physician. A customary fee is one that is charged by the majority of physicians in an area and a reasonable fee is a combination of the two.

To paraphrase Lord Atkins: Sometimes power placed in an organization becomes somewhat dangerous sometimes, unless it is controlled.

PRESIDENT PASCHAL: If it is agreeable with Dr. Jones, I'll ask Dr. Rogers to read the resolution that was agreed upon at the joint meeting.

DR. ROGERS: Mr. President, the joint meeting of the Committee on Blue Shield and the Insurance Industry Liaison Committee of the Medical Society of the State of North Carolina, November 4, 1965 at High Point, North Carolina.

This is the final resolution, as amended.

WHEREAS, there is an agreed need for an exploration regarding the prevailing fee study in this state, and,

WHEREAS, the Blue Shield organization has been requested by the Medical Society of the State of North Carolina to be Part "B" carrier (P.L. 89-97) and that this request has gone to the Department of Health, Education and Welfare, and,

WHEREAS, there appears to be fear concerning certain results pertaining to this survey: The fear, first, that some of the results may not remain confidential; the fear, secondly, that there may not be an adequate determination of the type of study done; the fear, thirdly, that the results may not be made fully available to the Medical Society of the State of North Carolina, and,

WHEREAS, Blue Shield has the mechanism to handle such a survey, and,

WHEREAS, the Blue Shield Committee is under the control of the Medical Society of the State of North Carolina and/or the Executive Council,

Be it therefore,

RESOLVED, that a survey be instituted by the two Blue Shield Plans under the aegis of the Blue Shield Committee acting under the jurisdiction of the Executive Council of the Medical Society of the State of North Carolina subject to the two following provisos:

First, that the determination of the type of study to be done by Blue Shield, subject to the jurisdiction of the Executive Council of the Medical Society of the State of North Carolina, shall not, however, preclude the Executive Council from designating the other members of the Society to participate with the Blue Shield Committee in the type of study to be done; and,

With the second proviso that the results of the study be made fully available to the Medical Society of the State of North Carolina through its Blue Shield Committee and, at the discretion of the Executive Council, also to any committees of the Society having need

for the data secured in the pursuit of assigned Medical Society business.

DR. BEDDINGFIELD: I think that basically this is a good compromise and although these are largely personal reactions to considerations that were involved, I believe it is a compromise.

I think that it represents concessions from the school of thought espoused by Dr. Jones, concessions from the Blue Shield Committee and perhaps some from Blue Shield itself, if it's adopted.

Dr. Jones is our President-elect. He's going to be in the "Hot Seat" next year.

It is the tendency for any organization to blame those then at the helm for any difficulties that may come about and I don't envy Dr. Jones, the President-elect, for next year at all and I think, very wisely, he has asked us to consider the ramifications of everything that we are about to do here.

Personally, it appears to me that some determination of fees has got to be made, so that we might live under this law that none of us wanted.

I agree with Dr. Rogers that the mechanism is at hand. I personally, believe that the law says that the carrier—and I have heard no opposition to this from Council to Blue Shield being the fiscal intermediary for Part "B" in North Carolina, not from anyone.

If Blue Shield is to be the fiscal intermediary, how shall they determine which fee is to be paid unless a fee study is made.

Many physicians in the state will be performing services under Part "B" for which Blue Shield has no information.

For example, let's take the example of flu immunization. This isn't covered under Blue Shield contracts at all, yet this would be covered under Part "B".

I will move the adoption of the recommendation of the joint committee.

DR. RAIFORD: I'll second the Motion.

The Blue Shield Committee is a function or an arm of the State Society, per se, and no more. The Boards of Trustees of the two Blue Plans, Hospital Savings and Hospital Care, comprise one-third doctors; one-third hospital administrators; one-third laymen—four of each.

What provisions are made in this resolution or this plan, for a limitation of time?

In other words, is this prevailing fee concept subject to annual or bi-annual revision?

The point is how can you avoid being locked in?

PRESIDENT PASCHAL: You're not locked in.

DR. ROGERS: By written notice to the Blue Shield Plan handling this prevailing fee concept, you may change your fee within ninety days, or you make written notice and in ninety days, the tape is changed that this is your fee for an appendectomy instead of the fee that was there three months ago.

DR. RAIFORD: Will this be a continuing up-dating?

DR. ROGERS: Yes, sir.

DR. RHODES: There's a provision within the law that provides that if you have an assignment from the patient for the fee, you accept the total fee as it's set up in whatever fee schedule you have, but if you

do not accept an assignment from the patient, then you are privileged to make your own fee charge—that's in the law.

DR. ROGERS: By quoting, reading if I may, and I think it will clear the thing up completely.

The prevailing fees program while providing paid-in-full benefits, is not based on a fixed fee schedule which every physician is required to accept regardless of its being applicable to his practice of charging patients.

The control consists of an internal plan check relating the prevailing fee to others.

If this check puts the physician in question over the ninety percentile, he is no longer a participating physician.

Requests for fee increases are approved if the increased fees are still within the current ninetieth percentile limit of actual area charged and the physician is charging, the same amount to all of his patients for similar procedures or services.

A physician may request additional compensation from Blue Shield by filing a special report with his claim. Provisions are made for review of claims usually in cooperation with the local medical society when unusual circumstances require that a physician's fee exceed his normal charge.

DR. ROGERS: Let's take an area of population, or a city, or a group, and every doctor in that city will send in his usual and customary fees.

Then when all of these figures are in, then the ninety percentile group is determined—ninety per cent of the doctors and what they charge.

Now, it has been found from studies that have been carried on in other areas that when these doctors are sent these schedules to fill out to give their prevailing fee, that ninety-five per cent of them fall into one group.

Ten per cent will be above.

All right!

Then when the computer tells us that your fee is in the ninety percentile group, you're paid.

Now, you may send in—let's set a hypothetical case—for an appendectomy. You may send in a fee of \$150 and another doctor over here may send in a fee of \$100.

The man over here is paid his fee. You're paid more than he is, but that's the fee that you set and that's the fee that he sets and as long as you are within ninety per cent range of the doctors in your area, then your fees will be paid.

DR. BEDDINGFIELD: The whole intent of the ninety percentile, I think, is this. If you have ten surgeons in a city and nine of them submit a fee for an appendectomy, let say and their fees range from \$150 to \$175. You've got one guy who says, "My fee is \$500 for an appendectomy".

Obviously, with public funds paying for the thing, there has to be a ceiling somewhere along the line.

DR. RAIFORD: Question.

PRESIDENT PASCHAL: The question has been called.

All in favor of the motion to institute this survey,

let it be known by raising your hand. Opposed by like sign.

It's carried without dissent, but, I note, not unanimously.

(The meeting recessed at twelve-fifty-four o'clock.)

SUNDAY AFTERNOON SESSION

November 21, 1965

The Special Called Meeting of the Medical Society of the State of North Carolina reconvened at two-one o'clock, President George W. Paschal, Jr., presiding.

PRESIDENT PASCHAL: We have two other matters: Item five: Consider authorizing and delegating the appointed committee to function in representation of the Society in developing and projecting a North Carolina Planning document to effect a study of a system of medical research and medical care related to Cancer, Heart Diseases and Stroke.

You will recall at an earlier meeting, you authorized your President to appoint three representatives of the Society to meet with the Deans of the three medical schools.

These representatives were appointed and for your information these were Dr. Ladd Hamrick of Shelby; Dr. Robert H. Shackleford of Mount Olive; and, Dr. Hubert M. Poteat, Jr., of Smithfield.

Our representatives met with these deans on October 13 and once since. I didn't want you to labor under the assumption that the Council had given them blanket authority to do anything that they wanted to as far as the development of this planning phase was concerned, unless we came back to the Council and had appropriate authorization by the Council.

Since August this planning group has been expanded to some degree.

They invited members of the Hospital Association. They hope to invite members of the Public Health, Department of Public Health, and the Hospital Care Commission.

We met with Mr. Rankin just last week, before the meeting of the General Assembly and pressing affairs at the time made it impossible for him to contact the Governor.

This is a long-range, comprehensive studying and planning undertaking.

I do happen to know that they are in the process of looking to see if they can find someone who might be available to act in the capacity of executive director and they're doing this because they need to get started with it, as there's some urgency about it.

They are going to be in a position to apply for a grant and if a grant is given to them, they don't want to wait until that time to start.

The Deans of the three Medical School have been active with this. They've had several conferences with the people in NIH, I think, who will administer this and they're told, I get the impression that North Carolina has the opportunity of being one of the seven or eight areas receiving considerable favor at this time. They do think that North Carolina is in a position with the three medical schools that are here, working as they do together, and having a good liaison one with the other.

So, it is with that in mind, to give them that authority and go ahead and proceed with this, knowing at the same time that if at the end of their study it doesn't seem feasible and doesn't seem practicable, that what has been done will not be binding and that it can be rejected.

What is your pleasure concerning this?

MR. BARNES: Mr. Chairman, would you clarify for the group the difference between the advisory council and the executive committee.

PRESIDENT PASCHAL: Yes, I'll try to.

The Advisory committee is one of a very broad nature in which it would have representatives from the medical profession, representatives from the various allied health fields, the Hospital Association, the nursing people, the medical technicians, probably, and interested and knowledgeable lay people who are concerned and informed about this type of problem.

Now, then, the advisory committee would be one we would hope the Governor would appoint. Provisions are made and spelled out, I believe, in the legislation for this representation.

For the organization of an executive director, there will be three liaison representatives from the Medical Schools; then, there will be three liaison representatives from the Medical Society; then, one representative from the Hospital Association; one from the State Board of Health; one from the Medical Care Commission.

The ex officio members which would be the three Deans, the President of the State Medical Society and the Dean of the School of Public Health.

That would be the executive committee.

It is quite likely that the advisory committee itself, while being rather broad, would be rather numerous and it is thought there would be forty or fifty members of that particular advisory group.

DR. GARRARD: Where would the money come from to pay for the executive director?

PRESIDENT PASCHAL: That would come from the grant, in part, but the Medical Schools now, the Deans of the Medical Schools say that they will underwrite this director in the beginning and they figure it will cost \$25,000, possibly, to get a man of the type and calibre that they want, and that they'll give him some kind of a tenured status on the faculties of medicine at the respective schools, and they would equally share his cost for the time being.

They would underwrite it in the beginning.

Now, there's some \$26 million I understand to be allocated in this initial phase of the planning and a portion of that will be allocated to North Carolina, if and when our application is accepted.

DR. DUCK: I make the motion, Mr. Chairman, that the representatives of the Medical Society, as have been previously appointed by you, be empowered to proceed in their designated capacity with the overall Council on the executive committee and the advisory council.

PRESIDENT PASCHAL: Is there a second to this motion?

DR. GARRARD: I second it.

PRESIDENT PASCHAL: All in favor let it be known by saying "aye"; opposed by like sign.

That motion is carried.

Now, finally, is item number 6: Consider the authorization of the founding of a Medical Foundation as a subsidiary of the Medical Society of the State of North Carolina and to outline its purposes.

This was thought important to include at this time because of the possibility that you'll be involved in receiving or spending a considerable amount of money within the next six months.

It has been suggested, either by our Executive Director or our Counsel, that there might be something of an advantage to the Medical Society to establish a foundation, thereby saving considerable sums as far as taxes are concerned.

MR. ANDERSON: Trade organizations, while exempt from certain income taxes, insofar as related income, that is dues and income earned from related activities of the corporation, they're exempt from income tax laws, but unless we're classified as a tax exempt organization under sub-section three as a charitable corporation, we would not be exempt from income taxation for unrelated income or contributions made to the Society by anybody—they would not be deductible as a gift to a charitable organization.

So several of the societies around the country have found it useful to organize a charitable corporation, called a foundation.

The organization of such a corporation would insure, if we could get it approved by the Internal Revenue office in advance of getting into operation, would insure that any contributions made by any member to the foundation for any purpose, or any bequest left to the Society by any member or any other person, would be exempt from inheritance tax and would be deductible as given to a charitable institution.

DR. RAIFORD: I would therefore move, Mr. President, that the Council approve this in principle and request the President to appoint a suitable committee to draw up ground rules for this and present to the Council meeting in January.

DR. JONES: I second that motion.

PRESIDENT PASCHAL: It has been moved and seconded that the President appoint an appropriate committee to work with Mr. Anderson and bring it back to this board, at the meeting in January.

MR. ANDERSON: Would you provide in that motion some authority to make application to the IRS before January, if that is the opinion of the executive committee?

DR. RAIFORD: I meant to imply that, to secure any information or any decision from the IRS that might be available.

DR. GLASSON: I'll make a substitute motion that we authorize the establishment of such a foundation at this time, with the understanding that we don't necessarily commit any funds, but that we set up the mechanics of it, so that it can be of use to the Society as it's needed.

PRESIDENT PASCHAL: All right, you've heard his substitute motion.

Is there a second?

DR. SUMMERLIN: I'll second that. I don't see where we have anything to lose. If it's the decision in May that we don't want it, then we haven't lost anything except the paperwork that's involved.

DR. JONES: In effect, these motions are identical except the one doesn't hold up on any of the proceedings, but they are contingent upon the fact of how the House of Delegates will act in May.

All in favor of the substitute motion, let it be known by saying "aye"; opposed by like sign.

The motion is apparently carried.

(The meeting adjourned at two-fifty o'clock.)

SUNDAY MORNING SESSION

January 30, 1966

The Mid-Winter Meeting of the Executive Council of the Medical Society of the State of North Carolina convened at nine-fifteen o'clock in the Crystal Room of The Carolina Hotel, Pinehurst, North Carolina, Dr. George W. Paschal, Jr., President of the Society, presiding.

[Dr. John S. Rhodes delivered the invocation.]

[Whereupon Dr. Charles W. Styron, Secretary of the Society, called the roll and declared a quorum present.]

(The minutes were approved.)

DR. PASCHAL: We will have the annual statement of operations and the annual audit report.

MR. BARNES: Mr. President, we have here this morning the first draft of the auditors' report for 1965 and I might just simply refer to the fact that we had a profitable year, showing something like \$29,000 in profit in the operations for this year.

All of the revenues in the budget exceeded our estimates and the departmental expenditure budget for the most part were under estimated expenditures and I defer to Dr. Wayne Benton.

DR. WAYNE J. BENTON: I do think it's appropriate that we thank our president for holding the line on our budget so that we could get a profit.

I think, too, it should be noted that our Commissioners have not been sending in their travel expenses which has saved us a lot of money, and they are to be commended for it. Even though they're allowed to do that, they have chosen, on their own, not to charge the Society for their expenses.

I request that the budget report be accepted largely for information.

(The report was accepted.)

DR. BENTON: For your information, investments in Investors Mutual were 6.7 per cent last year. We'll see if we can't increase it for the following year.

On the advice of Counsel the Finance Committee of the North Carolina Medical Foundation, recommends that a non-stock certificate of incorporation, be formed.

Its purpose is to comply with the Internal Revenue Service regulations and applies to income from our surplus land; that is, the idea is to make it

possible so that we will not have to pay tax on the appreciation of our land between Raleigh and Durham.

This is the form that has been written by our Counsel and it's taken from the statutes as well as taking some of the Florida group ideas and this will be given to the Internal Revenue Service for their approval of it.

And, if they approve it, then we will have a written document so that we will be safe as far as our income tax is concerned with the Internal Revenue Service.

[Discussion held off the record.]

DR. BENTON: After studying this proposal in depth, the Finance Committee recommends to the Council that they order staff and our attorney to proceed in the implementation of this Foundation.

MR. ANDERSON: You may want to take this before the House of Delegates before the corporation is actually organized.

Before that time, this could be submitted to IRS for approval before the organization actually takes place with the Secretary of State's office.

DR. BEDDINGFIELD: I feel that the simple organization of such a corporation does not jeopardize the Medical Society in any way.

It simply gives us an instrumentality through which we might avoid placing ourselves in an unfavorable tax position; that we are not precommitting the House of Delegates or the Society but simply providing a structure for this Foundation and the most we could really lose, if we never activated the Foundation, is simply the cost of incorporation, \$100 and so, but the savings may be many times over.

PRESIDENT PASCHAL: This, I think, would appropriately be sent to the House of Delegates for their final approval, but the planning and the preliminary study and preparation could go on at this time, as Dr. Beddingfield has suggested, without jeopardy to the Society.

DR. BEDDINGFIELD: Mr. President, I move that the Finance Committee and our attorney proceed with the certificate of incorporation being considered by Internal Revenue Service as it's presented to the Executive Council and, moreover, the Executive Committee prepare a documentary presentation for distribution to the members of the House of Delegates so they may consider this at their next annual session.

(The motion was seconded and passed.)

PRESIDENT PASCHAL: At this time, I'll ask Mr. Barnes to make a statement concerning our schedule of savings at the First Citizens Bank.

MR. BARNES: I discussed this with Dr. Benton's committee last night and everyone is agreed that the treasurer of the Society, with the guidance and permission of the Finance Committee, may exercise judgment in placing any of the current revenues of the Society that are not going to be needed for some extended period, into a savings account in the fiduciary which the Society operates through.

Now, to the end that the Finance Committee and the Executive Council might know what was available in the way of interest producing plans in the fiduciary, I wrote to the Vice-President of the First Citizens Bank & Trust Company and asked him for a statement on what they have to offer and this is a letter from him, dated January 11, addressed to me and it says:

Currently we are offering four forms of savings:

1. Pass Book Savings on which we pay four per centum per annum compounded quarterly.

2. 4-1/2 per cent Savings Bonds (Certificates of Deposit) on which the rate of interest is guaranteed for five years. These bonds may be redeemed on any quarterly renewal date without notice or within ten days thereafter. Interest checks will be mailed semi-annually.

3. 4.80 per cent Savings Bonds (Certificates of Deposit) on which the rate is guaranteed for three years. These bonds may be redeemed on any three months period from date after they are held for six months. The holder must give written notice of his intention to cash the bond ninety days before encashment.

4. 5 per cent Savings Bonds (Certificates of Deposit) are issued for one year with interest payable at maturity. They may be cashed in an extreme emergency prior to maturity.

We discussed this a bit last night and we thought the best thing to do was to make the deposits in regular savings at four per cent compounded quarterly. Then, you'll have freedom to move in and out as you need to; from the standpoint of operations, I suppose that's what we ought to do.

PRESIDENT PASCHAL: I think the Finance Committee is authorized to exercise their judgment in the investing of these funds. Now, state-wide billing.

MR. BARNES: This has been a rather fantastic experience following our state-wide billing on the 22nd of December. We've never had more than maybe \$400 or \$500 coming in on dues before the end of a year for the succeeding year.

But, interestingly enough, there's a marked response to state-wide billing and some 300 members did respond before the end of the year, so that we had a sizable income for 1966 accruing at the end of the year.

We've already remitted for the component societies that we're collecting for and we've already remitted to AMA, and to PAC—I think something like 300 PAC members have contributed through December 31st.

In January, we've been just literally clobbered and we can't begin to tell you what the rate of flow of 1966 dues are for the month of January.

We have made an effort to receive the checks and record them; two, immediately go into the process of making receipts for them and immediately putting the funds in the bank.

And, it has just been too much of a job for us to

get together and get you a January report, but we will try to get some sort of summary of it early in February.

I think it has been a good idea. I will send every member of the Council a copy of the monthly statement of the operations so you can see how the state-wide billing has been and we have received very few complaints, or misunderstanding and we think it is working just like a charm.

And, we hope we're going to get the bulk of this dues proposition out of the way by the 1st of March and if we do, maybe we can work on some other things that heretofore we've had to string out through the whole spring months because of this process of collecting through county medical societies, in stages, with poor returns, and sometimes going on until April.

I think you all ought to be pleased with it.

PRESIDENT PASCHAL: We will accept this as information.

It comes to my attention that there are several areas in the state and several counties who do not completely understand the central billing process or the additional billing, so to speak, of the Med-Pac dues.

I would think that we're going to be involved with a lot of patient repetition here to get the membership informed and toward that end, I believe it would be helpful if we asked Mr. Hilliard to try to make a very condensed statement in the Bulletin to the effect that this is a voluntary contribution and that they should read carefully their statement, so they will understand the nature of the statement.

Now, I'll ask Mr. Barnes to consider the problem of requests to PAC contribution refunds.

MR. BARNES: Well, actually, Mr. President, there hasn't been a major problem.

We've had seven contributors to PAC make a request for refunds. Three of those seven withdrew their requests before we could determine policy through the Executive Committee of the Society as to what we should do about making decisions in the headquarters office about PAC contributions.

We thought that was a decision that PAC itself should make and the Executive Committee in a meeting in January agreed with our point of view.

And, Dr. Rhodes' Board met yesterday and I believe they're agreeable for PAC to make the refunds where there's a reasonable point to the request.

So as I understand, PAC has already made the four refunds, so it's not really a very material problem.

Now, I do think that perhaps Dr. Rhodes and Dr. DeCamp will be faced with some belated requests for refunds and somebody will be faced with establishing policy on that, that once a man has paid his dues and they have been processed and receipted and a membership card issued, should he be allowed to request and collect a refund.

Nobody has ever authorized the recognition of a request for a refund; as a matter of fact, there have been none and probably the same sort of policy should pertain to PAC.

Scarcely should a man be allowed, in my opinion, to come back and say, "I've changed my mind. I paid dues back in December or January. Now, I want to take them back!"

I think the billing was in line with what we were authorized to do, and so far as the PAC contribution entries on the billing form, it seems to me it was clear and there should not have been any misunderstanding.

DR. RHODES: I would point out, as you have indicated, perhaps there is some lack of understanding, generally, about this, largely because people don't read their mail, because a complete statement of this central billing was sent out to every county society president and in the December issue of the Bulletin, a defined statement relating to this alone was inserted.

However, that hasn't covered the subject and I agree we need to keep reiterating an explanation of this billing.

In regard to refunds, I think there may be some distinction between Medical Society dues and PAC dues in that they are voluntary and non-tax deductible.

Therefore, there may be a little distinction about how we might handle these in general.

I think we could follow the same procedure that has been indicated by the Medical Society.

And, the other point I want to make is that we are going to have to understand and use the money, I hope, wisely and we are open for suggestions from this Council for direction.

DR. LOUIS deS. SHAFFNER: I notice in the folder here, we've got a recommendation, a resolution, to go before the House of Delegates about the separation of Am-Pac and Society dues.

There is misunderstanding and sometimes a doctor will pass his bill to a secretary to pay this just as he pays a lot of bills that have to be paid and apparently they don't catch this voluntary payment.

I was under the impression from the House of Delegates and also from this Council meeting that these bills would be so listed, the dues part for AMA and state would be underlined and totaled and then AM-Pac added to that total with another total, so the fellow could pay either total.

This was not on the bill, as I understood it would be and, therefore, one total was there and you had to read a footnote to be sure what was deductible and what was not deductible and this has upset many of the members, who voluntarily came to me and complained about it.

And, I think it's going to be a detriment to the Society, especially if AMA dues go up. We're going to have a lot of unhappy people on this and I would like to put on record the complaints I've

heard and the feeling that perhaps we ought to consider further.

PRESIDENT PASCHAL: Thank you, Dr. Shaffner.

MR. BARNES: May I make one other comment for the information of the Council?

We sent the statement in duplicate and asked the member, in remitting, to attach one copy of that with his check and keep the other copy for his records.

While not all members have contributed to PAC, where they did not contribute, they have obviously scratched out PAC on the invoice they returned and wrote the check for the proper amount, so there has been no confusion, apparently, by those who did not intend to make PAC contribution.

I don't know, maybe it was sneaky, but the invoice was approved by the Executive Committee before we sent it out and by the Finance Committee.

DR. RHODES: It's not my intent or desire to have any part in any sneaky procedure and if this Council decides that it is a sneaky procedure, then I would like to see it changed.

DR. SHAFFNER: I am quoting the words that were given to me by the membership, not that I said it was sneaky. They thought it was sneaky.

DR. BEDDINGFIELD: Mr. President, as a member of the Wilson County Medical Society that submitted this resolution and also as a Councilor, we have in our Society people who are very much in favor of PAC operations, a few people who are luke-warm and a few who are opposed.

The vote in our Society on this resolution was unanimous encompassing all three groups, even those who were very much in favor of PAC.

A particular effort was made to get this in sixty days prior to the meeting of the House of Delegates. The Wilson County Medical Society is very anxious that the Council act on this and we're anxious that this go to the House of Delegates.

We believe the billing for PAC should be clearly stated, forthright, so that everyone knows what they're contributing. The Resolution says:

RESOLVED, that effective with the central billing of Medical Society dues in December, 1966, that solicitation of dues and/or contributions for AMPAC-MEDPAC be included, if at all, on a separate sheet of paper from the statement listing AMA, State Society, and local county society dues.

It is further resolved that copies of this resolution be mailed to all county medical societies in North Carolina and that this resolution be presented to the Executive Council with the request that it be transmitted to the House of Delegates for consideration at the May, 1966, Annual Session.

I move the Council recommend to the House of Delegates the adoption of this resolution by this Council.

DR. JOHN L. MCCAIN: I second.

DR. WELTON: Mr. President, I imagine a good

many of the Councilors and many of the other men here have heard some complaints.

It would be unusual—how many bills were sent out?

MR. BARNES: Approximately 3800.

DR. WELTON: Regardless of what form they were printed in, we have a few complaints, especially since this is a new form.

Nevertheless, this is the point—where we can't afford to injure our internal public relations, as well as our external public relations and in creating a situation that would stimulate some criticism that could be rectified, I'm in favor of rectifying it.

And, I agree with the suggestion that the AMPAC-MEDPAC dues be put on a separate slip of paper.

We need the cooperation of every member of our Society this year and next year and I think this is one way we could eliminate a little bit of criticism.

PRESIDENT PASCHAL: I would call to your attention that this does represent a change in policy if we do it, because we have collectively agreed to what has been done and the staff has been authorized to send out the invoices as they were sent.

DR. KOONCE: If the House of Delegates passes it, after the Resolution Committee has approved it, then it would be a change in policy.

DR. BEDDINGFIELD: We said there would be central billing. This was the policy decision and this is the point, that AMA, County, State dues, plus AMPAC-MEDPAC contributions are totaled together. It is misleading and that's the whole point of this resolution and I don't believe this was voted upon.

I think, as you say, the form of this invoice may have been approved by the Executive Committee, and I think this was within their province, and I think this is a criticism of that procedure. I think it's a valid criticism.

DR. RAPER: I'm agreement with the resolution, but having voted once for billing as it did, I don't see that the Council has to take any action on this resolution so that it's brought up before the House of Delegates or reconsidered at the time of our meeting before the meeting of the House of Delegates.

DR. BEDDINGFIELD: The Wilson County Medical Society would like to get this resolution before the House of Delegates at their next meeting.

DR. KOONCE: Well, we have it before the House of Delegates already.

DR. BEDDINGFIELD: On central billing?

MR. BARNES: Yes, it's before the House of Delegates now.

DR. BEDDINGFIELD: I move this be received as information.

And, I remove the motion for approval.

DR. McCAIN: I'll accept that.

For clarification, the Wilson County Medical Society was wholeheartedly in favor of this central billing. They thought it was a very good service.

This is in no way a reflection on the central billing service.

(The motion carried.)

DR. PASCHAL: Now, we will proceed to item six, the prevailing fee study proposal. This is a report by Dr. Max Rogers who is Chairman of the Committee on Blue Shield.

I would point out that the Council has authorized the proceeding with the implementation of this study.

I would further call your attention to the fact that, regardless of what action is taken here today, our decision about what we're going to do with the prevailing fee study and the information that comes from it will not be considered until that phase is complete and it's brought back to the Council for their consideration.

It might be from a determination of the study, that the Council might reject the thing, but right now it's in the process of being worked on so that it will be accomplished.

At this time, we'll ask Dr. Max Rogers to give us a progress report.

DR. MAX P. ROGERS: Mr. President, subsequent to the September 26th meeting of the Executive Council that went on record as favoring Blue Shield for administration of Part "B" of HR.89-97 and authorized the prevailing fee survey, after joint discussion between the Blue Shield Committee and Insurance Industry Liaison Committee, I can report the following developments of this Committee in action.

On November 4th, Blue Shield Committee and the Insurance Industry Liaison Committee met together.

The final recommendation was that a survey would be conducted under the aegis of the two plans, two Blue Shield Plans, the Blue Shield Committee and under the jurisdiction of the Executive Council of the Medical Society of the State of North Carolina, with the proviso that the Executive Council would have the right to designate other members of the Society to participate in the study and the results of the study would be made fully available to the Medical Society through the Blue Shield Committee at the direction of the Executive Council.

Following this, the President of the State Medical Society wrote a letter to the Secretary of Health, Education and Welfare requesting on behalf of the Medical Society that the two North Carolina Blue Shield Plans be made joint carrier.

In the December 1965 issue of the *North Carolina Medical Journal* it contained an editorial summary of the Committee and Council actions and Dr. Paschal devoted a President's Page to an explanation of prevailing fee concept.

At the present time, Hospital Care and Hospital Saving Association have the administrative task force to implement the prevailing fee survey.

An explanatory "Handbook for Physicians" is in the proof stage at the present time and ready for

printing, which can be quickly reproduced in any number needed.

It is planned that the handbook will have a copy of the fee schedule for the doctor to retain and attached survey forms to be returned to the Plans.

This Handbook, I feel, is going to try to answer all of the questions that the individual physicians over the State will have with regard to the purpose behind the survey, and what can be gained by the prevailing fee survey.

Along with this, we are considering plans of educational meaning to the various physicians over the State, so that when this survey form reaches them they will know the why and the wherefore, so that, then, the reports can be brought back, tabulated, various profiles be standardized so that then we will have a concrete set of facts to be brought before the Executive Council.

If the Blue Shield Plans are appointed carrier under Part "B" of the Medicare Act, the Plans will conduct a survey state-wide.

If not, consideration will be given then to conducting a survey in various test counties.

National Blue Shield has confirmation in writing with Mr. Arthur E. Hess, Director, Health Insurance, Social Security Administration, that intermediaries will not be required to use existing benefit scales and that prevailing fee programs would be an acceptable method for determining the usual and customary charges of physicians.

This is most important because as you read the law, the fiscal intermediary under Part "B" must furnish to the Department of Health, Education and Welfare, a schedule of prevailing usual and customary fees and this must be acceptable.

Now, the criteria for this is where the charge is, one, the physician's customary charge for the service provided; two, consistent with the prevailing charges in the locality for similar services; and, three, not higher than the charges that are applicable for comparable service under comparable circumstances to the policy holders who are subscribers to the intermediary.

Those of you who have read into this law can see the diverse ramifications and involvement in this thing.

And, it is our belief if we can develop this prevailing fee concept, we then can qualify to furnish the schedule that would be acceptable to HEW, because we have that in writing that the prevailing fee concept is acceptable to them.

Therefore, the Blue Shield Committee recommends that the Medical Society continues its support of Blue Shield as administrative intermediary for Medicare Part "B" benefits as the organization most responsive to the guidance at policy level and recommend the carrying out of the prevailing fee survey so that the Blue Shield Committee and the Executive Council can finally decide whether this is a feasible way or not of determining what is reasonable and customary, and reasonable allowances for physician services.

As far as the plan is concerned, the Council has approved that we conduct a survey. This requires no further action. There is no recommendation here.

But, the plan of the survey, as I mentioned in my report, is the production of a handbook which is in the proof stage now and almost ready for printing; the handbook is an explanation of the survey.

The handbook will contain two sets of proceedings.

The physicians will be asked to, first of all, state his particular specialty and then to fill in his usual and customary fee for that particular procedure.

This schedule will contain procedures that will cover all specialties so that a neurosurgeon will fill out the procedures he does, as well as each individual specialty.

This also includes the office visits, injections, etcetera.

Then he retains a copy of this survey, of what he has put down and the other copy is sent in to the Blue Plans.

This information, then, is computerized.

Then, a profile is developed for the particular physician. This is the way that we determine the prevailing, or the usual, customary fee for a particular area, a particular doctor, a particular procedure.

But, it has been the experience with the other plans who have put this plan to useage, this answers the question for each specialty group, but as far as the technique of the survey is concerned, it will be a handbook that will be sent to each doctor. He writes down his usual fees. He returns a copy to us and it is on this that we develop the prevailing fee for a particular area.

There has been some confusion about the business of using income levels in service plans.

This, of course, is not true because under the prevailing fee concept, there is no service plan, there is no income limit, and I think this is important to bring out.

The survey will be conducted and the results of this will be returned to the Council and then it will be up to the Council to decide whether or not this is a marketable plan for Blue Shield.

DR. WELTON: I would like to know more specifically who's going to draw up the wording of this handbook and questionnaire and what bio-statisticians have been consulted and so on.

I've had a little experience with surveys myself and this is an extremely important—

DR. ROGERS: Yes, sir, in answer to your question, the wording of this has been worked out by the professional staffs of the two Blue Plans here in North Carolina, under the guidance of the National Association of Blue Shield Plans and utilizing the experience of the other plans who have conducted these surveys, utilizing all of the information to develop the correct wording, the right wording and so on.

As far as the bio-statisticians are concerned, we have these men on the staffs of the two Blue Plans who are responsible for the computerizing

of this material and so on.

These technical details of the statistical part of it, of course, is left up to the statisticians on the staffs.

PRESIDENT PASCHAL: Thank you.

DR. GARRARD: I'd like to ask you, will our Blue Shield Committee designate what areas of the state will be surveyed.

I have heard just recently that two other states were very unhappy with the surveys because in one state the survey was limited to the Ford Company and the other to General Motors, and it did not include a wide range of areas and economics and the type of practice at all.

If our committees exercise enough control, we could get a representative sampling from all over the state. If not, if we limit to some big company like Old Gold, they are not representative.

DR. ROGERS: As discussed previously, Dr. Garrard, the ideal situation is if we do not do the survey statewide, the survey done on a test basis, will be to consider like-economic areas, like-population areas, and so on, so that we can get a cross section of the urban and rural areas, that sort of thing, and all of this will be put together.

So, we don't base everything on one group over here and forget the whole state, or that we don't take the eastern counties where there schedule fees are lower in comparison, say, to Charlotte, or Winston-Salem.

Each individual area will develop its own profile of needs, so that it will be a true usual and customary fee.

DR. RAPER: As a matter of information, did you say your fee schedule must be submitted to HEW and be shown that it is not above what is usual and customary?

DR. ROGERS: No, sir, we do not submit fee schedules to HEW. We have to show proof that the fees that are paid are reasonable, usual and customary, so forth, and HEW has told us, or told everyone, that a prevailing fee concept is acceptable.

So if an intermediary has a prevailing fee schedule, then this is acceptable.

But, we do not send those fees.

But as long as we show proof that we have the usual and customary charges, then billing can be done directly to the government.

PRESIDENT PASCHAL: Thank you, Dr. Rogers.

Dr. Johnson:

DR. AMOS N. JOHNSON [AMA Delegate]: Mr. President, I want to say a word.

I have some access to experience and opinions of those in other states and those in HEW and Washington. I have helped in discussions with Wilbur Cohen and Dr. Lee, personally, in a small group about this and I'm concerned that we are, perhaps, in the process of rushing into something that isn't at this time essential.

Mr. Cohen and Dr. Lee said in the presence of five of us who were meeting with them, from the top

level of AMA, that it wasn't necessary that every state establish and have available to submit this schedule.

That in the states where this was to be implemented by the presently operating Blue Cross and Blue Shield organizations, that this information was, or should be, already available.

That Hospital Saving and Hospital Care, to be specific, have already had ample and sufficient experience to know when charges are excessive.

There is the potential of developing rigid regional fee schedules and handing it down in writing, whether it be with our State Medical Society Council, or whether it be later filed in Washington and it's my opinion that it will be computerized and taken over by Washington.

And, in this conference, in the business of talking who would be the fiscal intermediaries in various states and who might have this job, in the wording of some of the answers, Mr. Cohen indicated that perhaps in the not-too-distant future Social Security Administration, perhaps in conjunction with HEW or alone, would take over and be the fiscal intermediary themselves in each of our fifty states.

And, I asked the gentleman if he was implying that after the states had gotten the kinks out and the local fiscal intermediaries had done the hard work and computerized all the information, would it be logical to believe that Social Security Administration would be in the business of taking it over and he said this is a possibility.

Now, in my opinion, we are in the process, if we rush into this—whether it be at our expense or at Blue Shield's expense, or whether it's going to be at the expense of HEW or Social Security—if we rush into this, we are in the position of pushing ourselves into something that I believe has as much, if not more, potential for harm as it has good.

And, this is something we can always come back to in certain areas where this proposition has been worked out in a different area, on a different understanding.

I think perhaps Dr. Garrard—were you referring to Jefferson County in Kentucky?

DR. GARRARD: Yes, to Delaware and I think out on the West Coast, too.

DR. JOHNSON: Well, in Jefferson County in Kentucky, the big plants there have worked out a system and it's working out very well with them.

Instead of setting up an acceptable usual and customary fee schedule, they've worked out a system whereby all fees that exceed 90 percent of the fees that are submitted are questioned and evaluated.

The top ten per cent fees are given evaluation.

There, there is no hard and set rules of fees. There's a measure of flexibility.

And, I think in this particular survey that we might set up here, that we might perhaps, without there being an intent on the part of any specialty group to do this, that we might come up with a set of dual fees that we would be saddled with.

I think it best that we give a lot of thought to

this and before we cut a pattern, voluntarily, and put it over our shoulders that we may have to live with for the rest of our professional lives, that we look a little further down the road and not run scared.

Nobody in Washington has told Blue Cross-Blue Shield or any private company or this Medical Society that they have to have and submit this plan that we're talking about here.

And, sometimes in this business of working with the government and establishing things they would love to have us do for their future benefit and have us hide-bound by it, it might be well for us to have a little bit of patience.

We don't have to have this to submit it.

DR. BEDDINGFIELD: Mr. President, as I understand it, the action of record of this Council has been to authorize this study as an information collection to authorize this study as an information collection device, that it not be implemented in any way until it comes back to Council when it is completed.

That is my understanding of our policy action to date.

Dr. Rogers' report is simply a progress report as to how far they have moved along.

I don't believe his report indicated any change in previously voted upon accepted policy of conducting the survey as an information collecting device.

Point two: I have a somewhat different interpretation of the events in Jefferson County, Kentucky.

I talked to some of the same people that Dr. Johnson has talked to and what he says is true about the 90 per cent level, but this was arrived at by a study of prevailing fees in Jefferson County, Kentucky.

I talked in detail to Dr. Witton out there about how their study of prevailing fees went and, actually, in a recent publication sent out to physicians by National Blue Shield, there was an analysis of how this study had been made and how it was working out in Jefferson County, Kentucky, and it began with the self-same study we're talking about now.

Point three: This has implications, as Dr. Johnson has indicated, over and beyond Section "B" of Title XVIII of the Medicare Act and perhaps to our advantage rather than our detriment.

I refer to Title XIX, even now the Advisory Budget Commission is compiling the state budget for the 1967 General Assembly. There's a very good chance that North Carolina may go into Title XIX an expanded version of Kerr-Mills. If they go into Title XIX, to secure additional federal funds for the state, then beginning in 1967, by law, and we'll consider this in another action today—the state will have to pay physicians' fees for all indigent and all medicare indigent in the state.

In order that the State Board of Public Welfare may make budgetary projections to present in the next few weeks or months to the Advisory Budget Commission to be included in the budget to be presented to the 1967 General Assembly, there is going

to be some data as to frequency of various medical services, units of medical services rendered, fees for same and I predict that this Society is going to go on record as asking for usual, prevailing fees for this group of indigent and medically indigent patients.

We need, I believe, this information in our dealings with government under these new programs.

We need, I believe, this information in our dealings with government under these new programs.

I do not believe we now have such information.

I do not believe that Dr. Rogers' report calls for any new action. I think it should simply be received as information.

DR. WELTON: Mr. President, we have a relative value schedule. It has been approved by this Council, by the House of Delegates and it should satisfy any governmental agency in our state or in Washington, for that matter.

DR. ROGERS: As this Council knows, whenever the Blue Plans of North Carolina get ready to market a new contract, it must be done with the approval of this Council.

PRESIDENT PASCHAL: I would point out that if this survey is completed this will be privileged information and will be information that will be brought back to the Council for the Council's further consideration and for their action.

If they decide to reject it at that time, why, they will have the opportunity.

DR. JOHN GLASSON [Councilor, 6th District]:

I'd like to ask Dr. Rogers a question.

Do all physicians get the same lists of procedures, or are there different lists to different physicians, according to the specialty of the practice?

DR. ROGERS: There will be one book, one survey, which lists everything and then you will fill out the part that you are involved with and this way we only have one printing, one mailing and it will cover all specialties.

I think the advantage is this: Supposing this is received by general practitioners and by their hospital they are allowed to do a D&C or tonsillectomy.

Now, if we did not send that man any surgical schedules then he would lose that.

DR. KOONCE: Now, we have only one choice; to rescind that action which I'm violently opposed to, or accept this as information, and I so move.

PRESIDENT PASCHAL: It is moved that we accept this as information.

DR. W. OTIS DUCK [1st Vice-President]: Seconded.

PRESIDENT PASCHAL: Is there discussion?

(Mr. Barnes read two communications from Catawba County.)

(The motion was voted on. Dr. Jones and Dr. Welton opposed the motion. The motion carried.)

DR. PASCHAL: What do you want to do about the recommendation to the Executive Council from Catawba County Medical Society submitted by Dr.

MacLauchlin, which was read just now by Mr. Barnes?

Essentially, this asks us to:

That the Society take immediate steps to abrogate and rescind all existing agreements with reference to negotiated professional charges and further that the Society withdraw its endorsement of all service plans of insurance.

DR. BEDDINGFIELD: Mr. President, there are two parts to this communication, it seems to me.

The first is related to an action that Dr. Frank Jones is going to bring up on the existing posture of the Society regarding fees for welfare patients.

I believe you appointed him as Chairman of the Committee to report to this Council and he has a report ready that will take care of and is in sympathy with the first part of that communication.

And, I would suggest that the first part of that communication be deferred until Dr. Jones makes his report and then it can be considered together and save time.

The second part about rescinding all existing service contracts will not be a part of Dr. Jones' Committee report and I think that should be considered separately by the Council.

PRESIDENT PASCHAL: Let's defer action on both for the time being and let's proceed with the next item on the agenda which takes us to Dr. Jones' report, item seven.

Item seven, consideration of endorsing commercial insurance companies to HEW as intermediaries to administer benefits under 1965 Social Security Amendments; item (a) consider the formal resolution of Committee on Insurance Industry; Dr. Frank Jones to present this.

DR. JONES: In accordance with protocol, I will yield to the Commissioner of the particular Commission to which my particular committee is assigned, Dr. Welton.

DR. WELTON: Mr. President, I attended the last meeting of the Insurance Industry Liaison Committee and they have asked that this communication be presented to the Council.

RESOLVED, that the Councilor, through proper channels, submit to the Council the following statement.

This Committee of the Medical Society of the State of North Carolina does recommend by unanimous vote that the Medical Society of the State of North Carolina give consideration and endorsement to reputable commercial insurance companies who indicate a desire to function as a carrier under Part "B", Title XVIII, Public Law 89-97 equal to that endorsement already given by the Executive Council to the two Blue Shield organizations in North Carolina.

The Committee further recommends that the proper officials of the Department of Health, Education and Welfare be notified of the equal endorsement as soon as possible.

I have some similar requests from three County Medical Societies, Mr. President.

One is from Cabarrus County Medical Society:

The Cabarrus County Medical Society respectfully recommends to the President and the Executive Council of the Medical Society of the State of North Carolina that endorsement of ethical commercial insurance companies' applications to the Department of Health, Education and Welfare as fiscal intermediaries under the "Medicare Act" be given as full and equal consideration as has been given the Blue Cross-Blue Shield organization's applications.

Signed by John R. Ashe, Jr., M.D., President.

The next is from the Mecklenburg County Medical Society stating:

The Cabinet of the Mecklenburg County Medical Society wishes to express its desire in the selection of a carrier for "Section B" of the present Medicare statute. Our primary interest is to secure a carrier that will not in any way interfere with the present physician-patient relationship.

The Cabinet of this society wishes to recommend that due consideration be given to qualified commercial insurance company applicants as well as to the Blue Shield organizations.

Signed by John Woltz, M.D., President.

And, the next is from Andrew J. Dickerson, Chairman of the Insurance Committee of the North Carolina Chapter of the American College of Surgeons, stating:

Dr. Alexander Webb, President, the Council, and Committee Chairmen of the N. C. Chapter of the American College of Surgeons met on January 9, 1966. There was much discussion about the impending Medicare Program.

The conclusions included:

1. Need for fee differential to compensate a board certified man or A. C. S. man for his additional training.
2. More realistic fee schedules.
3. The difficulty individual doctors encounter with liaison with the now powerful Blue Cross-Blue Shield organization.

By unanimous vote, the Council of our State Chapter of the American College of Surgeons is requesting that the commercial health insurance industry be utilized as much as possible in the impending Medicare negotiation.

PRESIDENT PASCHAL: All right, Dr. Welton.

We have another communication from Haywood County Medical Society which might well be read at this time.

DR. RAPER: The Haywood County Medical Society will oppose and object to the use of Blue Shield as fiscal agent to handle Part "B" of the Medicare program. Some of our reasons are as follows.

1. We do not want to endorse a monopoly.
2. We feel that the Blue Cross-Blue Shield organizations have gotten out of control. Instead of remaining "a doctors sponsored program", they have

become a large bureaucracy. It seems that the control has shifted and this group, having grown more powerful, can ignore the needs and wishes of the medical profession.

3. Preservation of a competitive free enterprise system is one of our basic principles.

4. Although the State Society has representation on the Blue Cross-Blue Shield organization, this seems to be on paper only. For instance, with an unusual or difficult case, we can write a commercial insurance company and obtain either a reasonable answer or sometimes a fee adjustment. About all we receive from Blue Shield is a form letter from a clerk.

5. The Blue Shield fee schedules frequently are unrealistic, outdated and inflexible.

6. By giving the Blue Shield a monopoly, a mortal blow will be dealt to the health insurance industry in our state and will hasten more complete socialization of medicine.

PRESIDENT PASCHAL: Thank you.

DR. JONES: I would like to read into the record one point..

This is the report of the Reference Committee of the AMA in Philadelphia which I'm sure you're all very familiar with here; the following was noted in the extract of the records and it is as follows:

The concept of the prevailing fee program in the National Association of Blue Shield Plans should be noted as one of the methods of compensation in those regions where a prevailing fee program is approved by local state medical societies.

It is important to note the fact that when report "J" used the word "trustees", it more specifically reiterated the policy established by the House of Delegates in June 1965 that "reimbursement for the services of physicians participating in government supported programs should be on the basis of usual and customary fees".

Continuing the quotation from the report:

Report "G" of the Council on Medical Service be received for information, with the exception that the word "recognized" be substituted for the word "approved" as according to the prevailing fee concept of the American Medical Association. The end of quotation.

The only reason that they ran into it is to point out that this is the posture of the AMA. It says it's neither for it nor against.

It gives the words "usual and customary" rather than any other wording.

I believe, Mr. President, it was the intent of the chair to grant to some industry member, representing the industry, an opportunity to make a request in this area.

PRESIDENT PASCHAL: Thank you, Dr. Jones.

We do want to hear from Mr. Jones, but before we do that, I would like to ask Mr. Barnes to read a letter that was directed to David Koppelman of the Social Security Administration, Bureau of Health Insurance in Baltimore and this was writ-

ten after some consultation with Mr. Jones and others.

But, after this is read, we'll ask Mr. Jones to give what remarks he cares to make.

Mr. Barnes will you read that?

MR. BARNES: I might comment, Dr. Paschal, this letter was written after a meeting of the Executive Committee which you had advised on this particular letter.

Dear Mr. Koppelman:

Reference is hereby made to applicants emanating from North Carolina for your agency selection of fiscal intermediaries to administer benefits accruing to beneficiaries under Part "B", Title I—and it can be referred to as Title I or Title XVIII—of the 1965 Social Security Amendments. It is our understanding that such applications for selection by your agency may have supporting recommendations among which would be a recommendation from the State Medical Society.

You should be aware that on October 4, 1965 a recommendation authorized by the Executive Council of the Medical Society of the State of North Carolina specifically favoring the selection of the two Blue Shield Plans and added to it Hospital Savings of Chapel Hill and Hospital Care of Durham statewide administrative proposal, was contained in a letter to the Honorable John W. Gardner, Secretary of HEW. This contained recommendation has been duly acknowledged by the Secretary although we are not aware of any election taken on the Blue Shield application.

It has recently come to our attention that representatives from some commercial insurance companies perhaps representing the industry within the State of North Carolina, have developed an interest in being selected as the designated carriers in and for the state and have separately filed applications for certain companies operating therein. So, while the action of the Executive Council conveyed to Secretary Gardner under date of October 4, 1965 is still valid and is of record, the matter of multiple applications for industrial insurance companies will be considered in respect to possible additional recommendations in support of these applications when the Executive Council of the State Society meets on January 30th, 1966.

This letter, therefore, is directed to you as information and with no purport to impede your consideration of applications now before you in adequate form for selection as carrier intermediaries for Part "B" of Title I of the Act.

We shall promptly undertake to convey to you any additional recommendation which may develop as a result of the Executive Council's consideration of January 30, 1966.

Sincerely yours, George W. Paschal.

PRESIDENT PASCHAL: Thank you, Mr. Barnes.

I thought that this would be submitted as information.

Mr. Jones, we would be happy to have you come up and say what you like.

MR. R. J. JONES [Pilot Life Insurance Company]:

Dr. Paschal, the Health Insurance Council is very appreciative of this opportunity to make this statement.

As has already been indicated, two of our associates, were supposed to be here with me—Mr. Harding, who is staff representative of the Health Insurance Council called me last night and he and Dr. Thomas Alphin of Equitable Life went to La Guardia Airport and found that planes to North Carolina were not going out.

What I have to say is what Mr. Harding would have said. This is on behalf of the Health Insurance Council.

As you probably know, the Health Insurance Council is an association of eight insurance federations. The companies represented by the association account for more than 90 per cent of the health insurance issued by insurance companies.

I am confident that all present are aware that the insurance industry was not among those advocating the passage of the supplementary medical insurance plan, Medicare.

Our position was, I assure you, not because of our selfish desires, but rather because of a sincere conviction that such an all-encompassing law was not in the best interests of the American public in general and that government should concern itself only with social welfare of the truly indigent citizens.

Medicare, notwithstanding its opposition, is here and now.

In this circumstance, the insurance industry has again put itself into the Medicare picture as one of the prominent proponents of the voluntary health system and of its perpetuation.

And, further outlining the historical and on-going philosophers, may I ask you to keep in mind the one basic tenet that supplementary medical legislation to the present law must not be allowed.

Medicare must be contained to its present scope. This will require concentrated effort by all segments of the voluntary health system.

Even before the ink was dry on the Health Insurance for the Aged Act, amendments for expansion were given to the Congress.

This is the history of welfare legislation and the proposed amendments which will follow will be myriad.

In the face of such powerful adversaries, where lies our strength?

It lies in our ability as physicians and as providers of health care benefits to provide care and reimbursement for care which does not leave room for further government encroachment.

Medicare cannot, in many ways, help but set a standard to which we must address ourselves now and in the years to come.

As you probably are aware, the qualification criteria for prospective fiscal intermediaries for the hospital insurance program and the qualification

criteria for prospective carriers for the supplementary medical insurance program have been published by the Department of Health, Education and Welfare.

Part "B" of Medicare contains eight criteria, which must be met and of these eight, seven leave no room for question or emotion.

Number five, the one remaining criterion requires close examination by all parties concerned.

Number five reads as follows:

An intermediary must have a wide range of on-going professional relationships in the field of medical and health care throughout the area in which it would administer a supplementary medical insurance program.

There can be little question that in North Carolina such an on-going professional relationship exists between insurance companies and the medical care segment.

Of a population of 4,838,000—this was in 1964—close to 2,289,000 are covered by surgical coverage 1,029,000 have regular medical benefits; 672,000 are covered by major medical benefits and 2,395,000 by hospital benefits.

These figures amount to a net total of persons protected and eliminate duplication among persons protected by more than one kind of insuring organization, or more than one insurance company policy providing the same type of coverage.

With the fact that the criteria for qualification as a carrier established, it then becomes the basic philosophy and principles of the factors that medicine must consider carefully if it's to choose to make a recommendation regarding a carrier to HEW.

Here, let me point out that HEW has not committed itself to what, if any, regard be given to the recommendation by a State or a local medical society.

The first basic philosophy which must have consideration is that of the method by which the physician is reimbursed for his services by a third party.

The insurance industry has long held that it, in itself, has no right to interfere in the establishment between the doctor and the patient of the amount charged for service.

It has, in fact, in its major medical coverages historically accepted for reimbursement usual and customary fees for reasonable and necessary services.

At the AMA Clinical Session in Philadelphia in November at which time the House of Delegates noted the prevailing fee concept, the House hastened to reiterate and reaffirm the usual and customary concept in the following resolution.

RESOLVED, that the House of Delegates of the American Medical Association, meeting in Philadelphia, once again.

1. Reaffirm its support of the usual and customary fee concept as a basis for reimbursing physicians participants in government programs

at all levels of government, and,

2. Urge that the individual physician's usual and customary fees be agreed to by all third parties.

As is obvious in such an open-end concept as usual and customary, a method had to be created to educate the small segment of medicine which might assume usual and customary to be a concept which would allow inflation of prices for services.

As an answer to this need, medical societies at the local, state and regional levels, with technical assistance from the Health Insurance Council through its state committees, established the Medical Society Review Committee.

It is the primary purpose of such committees to provide impartial, professional advice with respect to fees charged by physicians which appear to vary from usual and customary.

Problems involving procedures rendered by physicians and other matters pertaining to the medical profession, or insurance, were also included in the considerations of a number of committees, although experiences to date indicate there has been too few such cases considered to make possible a measure of the value of the committees in those areas.

With respect to fees charged which have been questioned by insurers, physicians of organized review committees where they have been concerned with this matter only have recommended a solution regarding insurance payment under the particular circumstances of the policy and case, and have not attempted to alter or establish a physicians fee.

Physician members of review committees feel that the fee agreed upon by the doctor and patient is a matter which should remain within that relationship.

As of this date, the 34 review committees included in a March 1965 Health Insurance Council Report on Medical Society Review Committees in the United States, do not have judicial or punitive powers and in no way do they function as grievance committees.

They serve as fact-finding, advisory and educational media through which insurers, physicians and patients can communicate.

The March, 1965, study showed that on the basis of one million claims paid under usual and customary policy language—this is in the major medical contracts—from July 1963 to June 1964, payment was made on the basis of the original fee on 99.6 per cent of all cases.

Why have I so strongly emphasized usual and customary fees and Medical Society Review Committees?

Because its success has proven that medical care can be reimbursed on a basis which allows the physician freedom of pricing and through review committees physicians can be depended upon to educate whatever small segment within their ranks may escalate fees and to the working satisfaction of insurers.

Also, it is stressed, the insurance industry has

long recognized that multiple pricing practices for medical care serve the public badly and should be eliminated, not through legislation, but through recognition and action by those who as third parties pay the cost of care and through those primarily involved, the providers of care.

The matter of Hospital Utilization Review is one which I'm sure all doctors are aware that they must take the initiative and secure other procedure.

The health insurance industry's role in health insurance has been and will continue to be one of support.

The latest report on this subject is that of the Nassau County Medical Society in New York.

I have a copy of the report made by the doctors of Nassau County with the technical assistance of the insurance industry committee through the Council.

Now, the experience gained from our involvements is available for the guidance of those who will be involved with this activity and whose desire is to control the statutory demands rather than have the statute control them.

I will avoid detailed comment on Utilization Review and will say further that the industry stand is one of support for the doctor in his role in Utilization Review and in natural sequence, support of medicine which has so substantially met the medical care needs of the American public.

To summate, let me say it is the conviction of the insurance industry that in order for Utilization Review Committees to be effective, their purpose must be carried out on the initiative, direction and guidance of doctors.

The insurance industry has, can and will contribute to effectiveness through its vast technical resources, where this assistance is requested, to help chart and operate a pattern which will efficiently meet the requirements of this function.

There has been and presumably will continue to be deep concern with the quality of care with the advent of the Medicare legislation.

This concern is most apropos as one reflects on the effects of socialized medicine in Europe and the quality of care.

In Europe, however, private industry is given no role as it has been in Medicare and there was no great health insurance industry to exert its influence in support of voluntary medicine, nor to provide a history of noninterference in the provision and pricing of care.

Has anyone ever said to doctors, "Look, gentlemen, do you know that the insurance industry paid benefits, both for surgical and medical expense, in 1964 which total \$1,320,000,000 to about 90 million people and this with no involvement by the insurer in care, extent or quality or in the fee established between the patient and doctor? And, most pointedly, no demand upon the doctor that a predetermined fee must be accepted by him."

If this sort of health care financing has grown to this proportion with non-interference in the grow-

ing market, why should it be at all suspect in a static area where it will serve as a vital link to private enterprise in perpetuation of the voluntary medical system.

[Remarks made off the record.]

Dr. Alphin was to be here—he and I were merely to act as resource people to answer questions—Dr. Alphin's company, Equitable Life, has filed a proposal for a carrier under Part "B" under HEW and my own company, Pilot Life, and there are certainly others—I'm not familiar with how many.

I've been told in the aggregate there are some 90 companies.

DR. BENTON: Has Aetna filed too?

MR. JONES: Yes.

I had a discussion with an HEW gentleman and he confirmed the same thing that Dr. Johnson has commented on, that while a prevailing fee arrangement would be acceptable, it was not necessary and their choice of an insurance carrier would rely completely on the carrier if they chose to implement the program on the usual and customary basis.

Thank you.

PRESIDENT PASCHAL: Thank you, very much, Mr. Jones. We're grateful for this informative statement.

I can assure you, I think, that the action taken by the Council earlier was in no way discriminatory to the commercial insurance companies.

Gentlemen, you've heard this discussion of Mr. Jones.

Do you have further remarks, Dr. Jones?

DR. JONES: I don't think so, Dr. Paschal, except to say there is considerable thinking among the file, as well as the Medical Society, that many of them would like to see this left wide open as far as the choice by HEW as to the fiscal intermediary, or being the carrier which I think is a better term.

Further than that, unless there are some questions you want to put to Mr. Jones—there may be several states going on record as endorsement that might be of interest to the Council.

DR. BEDDINGFIELD: This Council, several months ago, endorsed Blue Shield and the Chairman of the Insurance Industry Liaison Committee, Dr. Jones, spoke in support of Blue Shield being named fiscal intermediary under Part "B."

Now, we are asked today, I suppose, to either rescind or endorse our previous endorsement.

In our judgment, we cannot hope to achieve unanimity of opinion amongst the members; witness, the communications that have been read.

However, we either have to vacillate, endorse multiple friends, dilute our efforts, or to stand fast on our previous action that was taken by the published deadline.

DR. JONES: It's my understanding, and I am subject to correction, that the reason that no other people came forward at that time was that the criteria had not been published for the intermediaries and that this was the only application that was avail-

able to this Society asking for endorsement.

Subsequent to that, the criteria did come out and this is the first opportunity that the industry has had to ask the Society for any endorsement since this is the first meeting held since that time.

PRESIDENT PASCHAL: Thank you, Dr. Jones.

We have had several communications from the insurance companies, and Mr. Jones included, and we deferred action until this time because we thought that this would be the more appropriate time to do this since the Council had taken previous action.

As I pointed out earlier, the action that was taken was not in any way discriminatory.

We didn't have the opportunity of much choice and the commercial companies were not brought into the picture to any degree at that time.

My letter to Mr. Koppelman in Baltimore did not close the door to the commercial insurance companies. It informed them of the action we had taken and it did say we would bring it to the attention of the Council at this time.

Now, this was in response to letters from Aetna, Equitable and Pilot Life and from representatives of the Health Insurance Council.

MR. JONES: We did not receive the criteria until, in my own office, November 22nd.

We filed the required filing by December 15th and my own company filed its on December 10th.

We were interested in this thing from the very date legislation became effective in July, so we had to wait until we got some guidelines from Wash-ceed, or what we did.

ington to determine whether or not we would pro-

PRESIDENT PASCHAL: Thank you.

I think we have to make a decision as to whether or not we want to do anything about it, or whether we want to maintain our previously stated position, or whether we want to make additional endorsements.

DR. BENTON: I have a question.

Under the law, can we have multiple intermediaries?

PRESIDENT PASCHAL: It's my understanding that they cannot.

DR. WILLIAMS: You're saying in one state?

PRESIDENT PASCHAL: In one region, or state. I think they refer to it as a region.

I think possibly in some states they can have one section of the state under one and another section under another. It's my understanding of the law.

DR. McCAIN: One of the reasons I've been in favor of the Blues, is that physicians are involved in the governing boards.

I'm just wondering if any consideration has been given to that, with these other independent companies.

DR. McCAIN: I wonder if they could make some provision for this in their proposal to us, that we could give consideration to, or perhaps they would like to speak to that.

PRESIDENT PASCHAL: Mr. Jones, would you

care to remark on that?

MR. JONES: I would like to say, Dr. Paschal, that to the comments just made, it was pointed out the usual and customary concept had been accepted with no problems, particularly, and 99.6 per cent of one million claims have been approved.

We feel that this provision of usual and customary concept could very appropriately go along and be handled in the manner which we handle it now—the liaison committee of the Society.

Also, I would ask: Has the representation you have in the Blue Shield area been effective? Do you feel it's necessary?

We do not know whether or not we would be privileged to have the Medical Society represented on a committee of any kind. I don't really know.

In talking to the gentleman from HEW, he very pointedly said the present practice of usual and customary was perfectly satisfactory to them in any carrier's implementation program.

DR. WELTON: Mr. President, it appears a motion may be in order. I think we should understand that if we do not take any action, we will have done, in effect, endorsed a monopoly.

So, I would like to make a motion that this Council go on record to give equal endorsement to reputable commercial carriers for Part "B" of HR 89-97.

DR. PASCHAL: You've heard this motion. Is there a second.

DR. JONES: Seconded.

DR. BEDDINGFIELD: Wouldn't you understand whichever carrier HEW designates, would be a monopoly because there would just be one?

DR. McCAIN: Just for clarification, is the endorsement—would it be for one specific firm like Pilot Life, or would it be for a federation of insurance companies, such as the Health Insurance Council?

Which would we be endorsing?

DR. WELTON: My motion was reputable commercial carriers. This would include those who have applied.

PRESIDENT PASCHAL: Now, Mr. Jones has spoken for the Hospital Insurance Council.

There's a motion on the floor but I feel that it would be in order to ask Mr. Herndon or Mr. Crawford if they have a remark to make at this point.

MR. E. HERNDON: Dr. Paschal, I think the questions have been pretty well answered.

In view of the number of people who have spoken, I don't think I have anything to add.

MR. CRAWFORD: It would be our hope and belief that Blue Shield organization in this state would have the finest chance to carry out the philosophy and principles that we're talking about.

PRESIDENT PASCHAL: Thank you, very much.

Is there further discussion?

DR. BEDDINGFIELD: One group appeared at the Council meeting prior to December 15th. They got the criteria at the same time as the commercial companies did.

The commercial Companies did not appear before us before that time and the same information was available to all.

PRESIDENT PASCHAL: That's true. I understand that the criteria came out about fifteen to seventeen days prior to deadline, so to speak.

MR. JONES: Mr. President, was not your endorsement made on November 5th?

PRESIDENT PASCHAL: September 26th, I believe.

MR. JONES: September 26th? The criteria had not been issued then. We received it November 22nd.

DR. BEDDINGFIELD: That's true, but in anticipation of criteria being prepared, one group appeared and said we will draw up a plan that will meet with your criteria; we will meet and discuss it.

MR. JONES: But, Dr. Beddingfield, if we had known we would have been privileged to appear on such an occasion, we certainly would have been there.

We were unaware that we had that privilege.

DR. BEDDINGFIELD: The liaison committee met the night before the Council meeting.

DR. H. FLEMING FULLER: Mr. President, may I say one word on this?

It was brought out that the Blue Plans had members of the State Medical Society as your elected representatives; with the exception of the speaker who happens to be the representative for Hospital Savings, the other two men, I can say, are very able. I think all three of us are listened to.

I think our counsel is sought many times in matters pertaining to the state medical society.

You apparently had some confidence in the ones you elected and I'm sure that Hospital Care has had the same experience—and Hospital Savings—and I can't help but feel that with the experience of the Blue Plans in our state with the Medical Society representation on that, and the consideration that your representatives have in overall policy and what not, to me—I'm prejudiced, I guess, but it looks to me like it's worked well and I can't see where it wouldn't continue to work well.

And, I can't help but feel that there is an advantage there that, as excellent as is the record that Mr. Jones quoted of the insurance companies—we respect them and we depend upon them as friends, that there is with your Blue Plans and your representation the Medical Society, have more of the say-so and more of the guns, of having control, let's say.

Thank you for the chance of saying my piece.

Is there further discussion?

PRESIDENT PASCHAL: Thank you.

If not, are you ready to vote on Dr. Welton's motion?

I want to get the vote on this for the record, so all in favor of the motion let it be known by raising your right hand—and I'll ask Dr. Styron to count.

SECRETARY STYRON: 9 to 5.

PRESIDENT PASCHAL: The motion is defeated

nine to five.

Now, we will proceed with agenda item nine, Report on North Carolina Med-Pac by Dr. John S. Rhodes.

DR. RHODES: Mr. President, very briefly, I would like to say first, I make no claim to political astuteness or resourcefulness, but I do believe that Med-Pac has a mission.

I'm sure no one here is naive enough to believe that those who support it and succeeded in passing Medicare had any idea that Medicare Act was the final action, but that merely it was the key step to total national insurance.

Ed Beddingfield and I appeared some months ago, before the passage of Medicare, on Channel 4 television program with the man by the name of Summers, Professor Summers, Professor of Political Science and Sociology from New Jersey who does a great deal of writing and if you will refer to your last issue of *Medical Economics*, an article written by this gentleman, I think you will realize, if you don't already know it, that the present medical bill just doesn't provide health benefits for 18 million old people over age 65, but probably encompasses 35 million people because of the extended provisions under Kerr-Mills.

So that we are already faced with a pretty extensive federal health program.

We should contain this and keep this, but apparently working in that kind of activity is not the answer, but the key lies in the election and selection of members of Congress who have philosophies which are in keeping with our own.

We have made some progress in the matter of education.

We've had a state-wide workshop in Greensboro in December, which was attended by some sixty people, perhaps a third of what we had hoped for.

Now, one of the things that we are particularly concerned about is the broadening of the base of this organizations and I mean by that, fundamentally, the broadening of the method and source of the members of the Board of Directors.

Up to now, the Board of Directors has been a sort of self-perpetuating affair and we don't believe that is the way to operate this organization and we are planning to alter our by-laws as soon as possible.

We have a by-laws committee meeting scheduled for this Asheville workshop, during this time, in the hope that our by-law committee could come up with some recommendation for altering our by-laws to broaden the base from which the Board of Directors is selected.

I hope we can take that out of the province of the Board of Directors itself and place it somewhere in the Medical Society.

We hope we will have a report on that by the next meeting of the Council.

PRESIDENT PASCHAL: Does anyone have questions for Dr. Rhodes?

If not, we will accept this as information.

Since Dr. Kernodle has been proposed by several people for membership on the AMA Council on Medical Service, what does the Council wish to do about this?

As one of your delegates, I'd like very much to endorse it.

PRESIDENT PASCHAL: Do you want to make a motion, Dr. Johnson?

DR. JOHNSON: I was going to say, in essence, what Donald said, that Dr. Kernodle has done an excellent job of representing North Carolina at AMA level through his work in Am-Pac for quite some while and during the past year, when he and Dr. Koonce were seated as delegates, he continued this work and he has impressed a lot of people who are in a position to evaluate the services a person is capable of rendering.

It would be quite a nitem of prestige for this state to have representation and I would love to see a letter go to Dr. Russell Roth as Chairman and also to Dr. Percy Hopkins who's Chairman of the Board of Trustees of the American Medical Association.

DR. KOONCE: I'd like to make such a motion that he be endorsed by this Council and the President be authorized to write a letter to Dr. Roth, and a copy to go to the Board of Trustees.

DR. DEWEY H. BRIDGER: Seconded.

(The motion carried.)

DR. WELTON: I would like to move that Dr. Beddingfield be endorsed and his name submitted to the proper AMA authorities for a position on the Board of Trustees and the Council on Legislation of AMA.

DR. JONES: I second that.

PRESIDENT PASCHAL: The four new members came on the Council on Legislation this year and I am told by a member of the Board of Trustees and also by members of the Council that it's unlikely that a new name would be considered, or a new member would be added this year.

But, I was also told that it would be helpful for any potential person to get his name before them and let them have the consideration of that and so when the vacancy does occur, he would likely get consideration because his name had been proposed earlier.

All in favor of the motion, let it be known by saying "aye"; opposed like sign.

The motion is carried.

[Dr. Beddingfield returned to the room at this point.]

I'll inform you of the action, Dr. Beddingfield.

The motion was to endorse you for membership on this Council and there were no dissenting votes.

PRESIDENT PASCHAL: We'll proceed to item ten which is the Legislative Report.

DR. BEDDINGFIELD: First of all, representatives of the Legislative Committee, along with other Society officers, attended the AMA Conference on

federal medical services in Chicago on January 20-21.

(Dr. Beddingfield commented briefly on pending national legislation.)

DR. BEDDINGFIELD: Many physicians have expressed concern about physician liability in serving on hospital utilization review committees.

Those of you who were at the Officers' Conference yesterday remember a hypothetical case that I presented in that discussion; namely, if a physician was serving on a hospital utilization review committee and it appeared a hospitalization was being abused and the committee voted that this was the case and reported the same to the attending physician and then to the hospital administrator, and he to the carrier, and later to HEW, so that the subsequently had a sudden, unfortunate and unexpected demise, would the physician serving on the utilization review committee be liable.

In order to protect our members from this type of civil liability. I move that we sponsor legislation either generated on our own or through the State Board of Health providing civil immunity to physicians serving on utilization review committees.

DR. WILLIAMS: Seconded.

DR. GLASSON: They have no authority to do the things which you have outlined and that these things are done by already existing committees of the hospital, such as the surgical staff committee or by the executive staff, and if any action is to be taken, that is taken by already constituted committees.

Therefore, this protection should be for those newly constituted committees of the hospital, which are to deal with this rather than utilization review committees.

DR. BEDDINGFIELD: It's my personal opinion that at the outset, for the first year or so perhaps, the hospital utilization review committees will be educational, statistics gathering, fact finding and gathering organizations, but I don't think even a few of us are naive enough to believe, in the event that our hospitals become crowded or overcrowded with the implementation of this legislation, they may become perhaps somewhat more than advisory, educational, fact collecting committees and as the pressure mounts, then the possibility of physician liability might increase.

I hope we'll never need it. I hope that no physician is ever sued for his activities on a utilization review committee, but I believe it behooves us in the Society to try and protect our physicians.

DR. RAPER: One way around this is when you have the committee appointed, by the by-laws, you give them no punitive action. That's what we've done in our hospitals.

But, I do think we need protection because utilization review committees are going to be used as whipping boys by the staffs if they find it necessary to say to a patient, whom they may want to get out, and they say to the patient, "Your case

has been reviewed by the utilization review committee and they feel that you should go home!"

PRESIDENT PASCHAL: Thank you.

Mr. Anderson, would you like to comment about this?

MR. ANDERSON: There is—in the last General Assembly, a statute was passed which makes it a misdemeanor for a patient to remain in a hospital after being told to leave and that advice is concurred in by one other physician.

That statute does not provide any protection, or immunity to the two physicians who certify that a patient should be discharged.

Perhaps that statute might be expanded to include some immunity from civil liability for physicians in that capacity, or serving in the capacity of utilization review committees, or any other position.

You never know what is needed until a test case arises but this perhaps would be looked upon with some favor by the Legislative Committee, if it showed a need for it.

DR. BEDDINGFIELD: This is a case where federal law requires, in effect, hospitals and hospitals require doctors to serve on utilization review committees. This is not an office which is frequently sought.

This is a public service to help carry out the intent of a vast federal program and I think a reasonable legislator would see that a physician would not be held personally liable for his honest service on such a committee.

DR. JONES: In connection there, I believe it is also standard practice that the report of the utilization review committee goes to the executive committee, say physicians having to do with the utilization staff then recommends to the full staff, and probably through joint conference back to the administrative unit, or the governing body.

If this wording could be changed just a little bit and rather than specifying utilization review committee, say physicians having to do with the utilization function in hospitals, then we would encompass any possible thing that could happen and not just limit it to the number of people serving on a utilization review committee, which has already been said, is a fact finding body and for the time being, educational.

DR. BEDDINGFIELD: I would accept that and I would amend my motion to encompass the thoughts expressed by Dr. Jones to attempt to generate legislation to provide immunity to physicians having to do with utilization review function in hospitals.

PRESIDENT PASCHAL: All right, you've heard the amendment. Who seconded it?

DR. WILLIAMS: I did and I accept it.

(The motion carried.)

DR. BEDDINGFIELD: As you will recall, in the last session of the General Assembly, we sponsored a bill for some state subsidy to assist in three year diploma schools.

Considerable support was received for this bill and we came close to getting some money, and this will be one of the things that will be considered by the Legislative Study Group.

DR. BEDDINGFIELD: There are groups, as you indicate, particularly organized nursing groups who would like to, I believe, abandon three year diploma schools, and they would like to have new systems of nursing education which are based on college campuses.

Now, rather than fight them on this specific score, we are in favor of all kinds of nurses, all nurses and better nurses for every group, and they find it hard to argue against this as a nurse group.

We said, yes, we're for the associate degree program on college campuses, we're for nurses of all kinds and I think we are. This is the policy we have espoused before every committee, but we are not in favor of new untried systems of nurse education, at the expense and the demise of a proven system that has supplied the most of our nurses.

All I ask for is a reaffirmation of that policy.

The Hospital Association have now come out forthrightly and unmistakably in support of our position in trying to get state money for three year diploma schools.

And, we've been told they will join us in our testimony before the Legislative Study group.

MR. ANDERSON: But no word from the nurses!

DR. BEDDINGFIELD: No, sir.

They attended the meeting but said they would have to have a meeting of the policy making group before they could give us the word.

As for funds available under the Aid to Education Act of 1965 for health service for underprivileged children, I would suggest, perhaps, a county medical society ought to be alerted to the possibility of this thing coming up and perhaps county medical society approval be sought by administrators on plans having aspects of health care and that physicians coming into knowledge of this, transmit this to their county medical societies for group consideration.

I can foresee what Dr. Koonce used to call the "fair haired boy" where you might have one doctor picked to do a large number of physical examinations and maybe sometimes at quite an attractive fee and other doctors maybe being left out of the program.

In the one county that I happen to know about, the County Health Director at the request of the County Superintendent of Schools, on his own has just drawn up a new fee schedule and saying "This is what we'll pay!"

He did not seek Medical Society counsel, officially. He talked to one or two doctors who are members of the County medical society, but it was not brought up before the county medical society for action.

I think it should be.

PRESIDENT PASCHAL: Are you suggesting we communicate this information to county society presidents?

DR. BEDDINGFIELD: I know of no other course for information?

DR. BEDDINGFIELD: Yes.
of action we could take on it, actually.

PRESIDENT PASCHAL: And, submit it to them
Governor Moore has announced his appointees to a commission to study the question of whether or not graduates of some schools of osteopathy teaching medicine are, or may be, qualified to be permitted to take the examination now required for the practice of medicine in the State of North Carolina.

I'm certain that the members of this commission have not yet met and I have reason to believe that perhaps through the physician representation on this commission that we will be somewhat aware of the progress of their study.

The chiropractic group across the state has sent communications to the present members of the General Assembly indicating that they will be back with a new bill in 1967 to amend the Chiropractic Practice Act.

There is a possibility that fees for chiropractic services could be provided under Title XIX at some future time and I believe that this is the motivation in attempting to have the scope of practice increased by changing the statute.

SECRETARY STYRON: Would it be appropriate to make a brochure out of the slides that Dr. Sabatier used in making his presentation because if they read it and they've got any intelligence whatsoever, they ought to reach certain definite conclusions.

(A motion was made and passed to accept this Legislation Report.)

DR. FLEMING FULLER (reporting for Utilization Committee):

Your Utilization Committee of the Medical Society of the State of North Carolina would like to present this today as guidelines which might be sent, with your approval to each of the presidents of each of the county medical societies and to the chiefs of staff of each hospital in North Carolina.

With the passage of Medicare Act, Public Law 89-97, the activation and implementation of the Utilization Review Program became the law of the land.

In order to qualify each hospital or facility must apply to the North Carolina State Board of Health for certification as a Provider of Service under P.L. 89-97.

In order to be certified, each facility must submit in writing a plan for utilization review of medical services rendered.

Exhibit I is submitted as a possible guide in developing utilization review forms.

(See sample on page 57 of 1966 Compilation of Reports.)

Each individual hospital or facility will devise its own mechanism for review on a sampling basis or in-depth as indicated by the requirements of that institution.

All cases admitted to a facility are subject to re-

view by the utilization review committee. Each facility shall determine its own sampling procedures.

These plans must meet the approval of the North Carolina State Board of Health as the officially designated agency for certification of Providers of Service under Public Law 89-97

(On motion the report was approved and the guidelines ordered disseminated).

(Dr. Jacob Koomen of the State Board of Health stated that his organization would handle the actual reproduction and distribution.)

[The meeting adjourned at one-ten o'clock.]

SUNDAY AFTERNOON SESSION

January 30, 1966

The Mid-Winter Meeting of the Executive Council of the Medical Society of the North Carolina reconvened at two-ten o'clock, President George W. Paschal, Jr., presiding.

PRESIDENT PASCHAL: Item twelve, consider vendor payment policy which was related to previous action taken February 26, 1961 with resolution to 1966 House of Delegates.

I believe Dr. Jones is to make a report on this.

DR. JONES: Mr. President, as you will recall, the Executive Committee appointed me to be associated with Ed Beddingfield, and our legal counsel to bring to the Council a certain resolution.

PREAMBLE:

In 1961, on February 26, a special called meeting of the House of Delegates of the Medical Society of the State of North Carolina did in effect rescind an action taken by the Executive Council earlier as such related to vendor payments to physicians under Kerr-Mills. This called meeting of the House moved and passed a later recommendation of the Executive Council in this connection which in substance said that the Society would not go on record as requesting physician vendor payments at this time in relation to the implementation of the Kerr-Mills Act.

The governments have chosen to interpose in an area long cherished by medicine as a part of their service to mankind. This area being the right to forego professional charges when the individual physician felt that in the interest of the commonweal he should, of his own free will and volition, abstain from making a charge for his service.

The position of the Society in 1961 is no longer tenable or reasonable in view of the developments that have occurred since that time; therefore be it.

RESOLVED: That, the physician, doctors of medicine, in the State of North Carolina, and the members of the Medical Society of the State of North Carolina do adopt the posture that when government in any form assumes any financial responsibility for an individual's health care, reimbursement for professional services should be on the same basis as other indispensable elements of health care; therefore, reimbursement for the services of

physicians rendering services to persons eligible under government-supported programs should be on the basis of usual and customary fees;

RESOLVED: That, this statement of general posture be also specifically applied in connection with the North Carolina implementation of Title XIX of Public Law 89-97 in whatsoever fashion such may be done.

Submitted by: Frank W. Jones, Edgar T. Beddingfield, and Legal Advisor, John H. Anderson.

Mr. Chairman, as a member of the Executive Council, I move this particular resolution be endorsed by the Council and transmitted to the House of Delegates in accordance with the usual procedure necessary for such procedure.

PRESIDENT PASCHAL: You heard the motion.

DR. RHODES: Second.

(The motion carried and instruction issued to send out notice.)

MR. BARNES: Read the following petition signed by 31 physicians of Catawba County.

A Petition to the Executive Council of the Medical Society of the State of North Carolina.

It is understood that the Department of Health, Education and Welfare in implementing Public Law 89-97 has not requested and does not require of the carriers a "prevailing fee survey". Feeling that such a survey on the part of the two North Carolina Blue Shield Plans is not necessary and could be detrimental to the physicians of the Medical Society of the State of North Carolina, we the undersigned thirty-one members of the Catawba County Medical Society are opposed to such a survey and respectfully petition the Executive Council of the Medical Society of the State of North Carolina to withdraw approval for such a survey until further consideration can be given.

It is also understood that other private insurance companies have expressed a desire to be carriers for Part "B" of Public Law 89-97. We are disturbed by the fact that the Executive Council of the Medical Society of the State of North Carolina has endorsed North Carolina be the joint carriers to the exclusion and recommended that the two Blue Shield Plans of other private commercial carriers.

The undersigned are opposed to the two Blue Shield Plans as joint and sole carriers and respectfully petition the Executive Council of the Medical Society of the State of North Carolina to give equal consideration and opportunity to those private commercial carriers who have requested such consideration.

Dated January 21, 1966.

It is signed by a series of physicians, amounting to thirty-one.

PRESIDENT PASCHAL: You've heard this. This is a request for action which we've already largely acted upon.

Well, shall we put it on the agenda and bring it before the House of Delegates at the May meeting?

I think it would be appropriate to bring it up for

consideration then.

If there's no objection, we will proceed along that line, without trying to take any definitive action on it at this time.

Report on Medicare Workshops—

The workshops were scheduled for Thursday and Friday here and of course, they were cancelled.

But we do have a communication from Dr. McLaurin, stating that the workshops have been rescheduled for February 18 and 19 in Raleigh.

DR. PASCHAL: Report of the Committee on Pharmacy where we have a problem arising in one district and we have a report that has been submitted.

DR. WILLIAMS: In October of this past year, an editorial came out in my hometown paper, regarding a matter that occurred down in Tyrrell County, the Second District, about a physician receiving a ten per cent drug kick-back payment from the local druggist and the editor raises the question: Can't medicine get enough money out of the people without doing this and what is happening to the Hippocratic oath and so forth?

Well, I photographed this and sent it to Dr. Paschal for advice and management of what he thought might be best and he felt that possibly this should be referred to Dr. Dees who's the Chairman of the Committee with liaison with the Pharmaceutical Association.

(Dr. Williams then read Dr. Dees report, including the court records.)

DR. WILLIAMS: I would move you sir, that we call this matter and this information to the attention of the doctor's local medical society and its appropriate committee for investigation and action on this matter and that we defer action for the moment until more information and investigation has occurred and is brought back to the Council.

DR. DUCK: Second.

(Discussion held off the record by Mr. Anderson.)

DR. PASCHAL: All in favor of the motion stated by Dr. Williams, let it be known by saying "aye"; opposed by like sign.

If you will submit that information to the component county involved—the board of censors of that county.

DR. WILLIAMS: I would like to state that Dr. Dees would like to submit a copy of his report to the Pharmaceutical Association and I don't think we should give him that.

PRESIDENT PASCHAL: I think it invokes personalities right now. Maybe it would be best until we get his side of it, to hold off.

This in a sense incriminates him before he has had a chance to be heard.

DR. BEDDINGFIELD: Mr. C. Joseph Statler, had written John Kernodle of his concern because of some directives that have appeared recently in some HEW manuals regarding the type of drugs that HEW would approve under Title XIX for various state plans that would include drug programs.

These two manuals that have come out of HEW say that special favor will be given those plans that employ generic name drugs and that have a formula system of allowed drugs under the program.

I would move that the Council go on record as opposing the compulsory use of generic name drugs under HEW programs and that we be allowed to transmit this information to Dr. Ellen Winston of HEW.

DR. WELTON: I second.

(The motion carried)

Item number seventeen, Consider recommendation of the Insurance Industry Liaison Committee re: (a) change in name and (b) status as a standing committee.

DR. FRANK JONES: presented a request.

(a) That the name of the Committee be changed to Insurance Industry of Insurance Committee,

(b) That the committee be accorded standing committee status by the Society utilizing the usual and customary procedures for the implementation of such action.

DR. JONES: I would move you, sir, that the Council express an opinion in this area and such opinion be attached as an endorsement, either pro or con, to its eventual submission to the House of Delegates which I believe would be necessary under these circumstances.

PRESIDENT PASCHAL: Is there a second to Dr. Jones's motion?

DR. WELTON: Seconded.

PRESIDENT PASCHAL: Now, is there discussion.

DR. BEDDINGFIELD: I think it's a very useful committee and should be a continuing committee, and should be a standing committee and recognized as such, in my opinion.

I would like to offer a substitute motion that the Council in addition to passing this along to the House of Delegates, pass it along with endorsement for approval of the request.

PRESIDENT PASCHAL: We have a substitute motion.

Is there a second to that?

DR. WELTON: Seconded.

DR. KOONCE: As point of information, in connection with this, there's no provision in the Constitution and By-Laws whereby a committee shall become a standing committee and shall be added to the list of standing committees without a change in the bylaws.

PRESIDENT PASCHAL: A recommendation would come from the Constitution and By-Laws Committee and I believe we are in a position to pass this action on to the Constitution and By-Laws Committee with a recommendation that they prepare appropriate changes for submission.

DR. KOONCE: For submission on the first item and for approval on the second?

PRESIDENT PASCHAL: That's right.

PRESIDENT PASCHAL: All right, all those in

favor of the motion, let it be known by saying "aye"; opposed by like sign.

The motion is carried.

We'll ask the Chairman of the existing committee, to draw up such a statement of function and scope for information of the Constitution and By-Laws Committee.

Now, item eighteen, Consider policy regarding coverage of emergency room by retired physicians retained by hospital on salary.

DR. RAPER: President Paschal, early in December, I received a telephone call from Dr. Patterson.

They had a problem where members of the staff wanted to have the hospital hire and pay salary to the semi-retired physicians in the emergency room, particularly for evening hours.

In the meantime, two other cases have come up and have been passed on to me with regard to this same thing.

So, realizing this does have some importance, I would like to have some statement from the Council as to what the feeling is with regard to hospitals paying salaries to physicians for staff duties and medical work.

Our recommendation is:

1—First, it's a physician responsibility in a state in an emergency room. It isn't a hospital responsibility per se.

2—In the last meeting of the House of Delegates, they spelled out in no uncertain terms, that the physician himself must bill for the work he does.

3—In any case where a hospital has a problem with regard to whether or not to do this, the AMA request that they consult and do this only after consulting with the county medical society and if necessary, with the component state society, before taking any action.

Now, the other two cases that have come to my attention with regard to salaried physicians, have to do with educational work in the hospitals and in the clinics—nurse and intern education.

DR. KOONCE: I am involved in this and Dr. Patterson spoke to me about it. They hired this man on a straight salary and you all know there's a dearth of personnel in emergency rooms in many hospitals.

The guidelines which have been set up by the AMA and which we have followed in New Hanover County is that the services in an emergency room can be somewhat rented out to a group of physicians and that's what we are doing now.

We have two already hired.

They are not employees of the hospital. Every case they see they put a bill in for. The bill is sent to that patient on their letterhead by the hospital. The hospital acts as a collection agency.

They pay their own insurance and their own social security. They are not employees of the hospital in any way, shape or form, except that they come under their jurisdiction of their various and sundry committees of the hospital.

They have a minimum guarantee of \$18,000 a year.

They get an advance of \$1500 a month on that salary.

If their services are more than \$72,000—we're hoping to have four—they will get that divided amongst themselves with a ten per cent deduction for collection services.

That has been approved by the AMA because we have written to them and it has been approved to the local county medical society, so there is a way to do it and there's a crying need in many localities.

It can be done properly without violating the principles of medical practice.

DR. RAPER: I think we should go on record against hiring of physicians by hospitals to do the work that should be done by the regular staff.

I think if the staff wants to hire somebody, that's a totally different thing. I'm talking about the hospital itself and the Board of Trustees. Where the staff has taken this on, this responsibility and handled it in a strictly professional way, which is good.

PRESIDENT PASCHAL: As I understand it, the recommendation of Dr. Raper is that we adhere to AMA stated policy and that would take care of this consideration.

Is there a motion?

DR. GLASSON: So moved.

DR. BRIDGES: Seconded.

PRESIDENT PASCHAL: It has been moved and seconded that we approve the recommendation of Dr. Raper.

If so, all in favor please say "aye"; opposed like sign.

The motion is carried.

Now, the Report of the Committee on School Health regarding proposed school health program advisory council and we'll ask Dr. Koomen if he'll speak to this.

DR. KOOMEN: Briefly, there is a school health coordinating program set up between our group and the Department of Public Instruction.

Some problems have arisen in the discussions between the two organizations and it was suggested an advisory council be developed to aid in decision making.

PRESIDENT PASCHAL: Do you have a recommendation to the Council, Dr. Koomen?

DR. KOOMEN: That we delay until you and I have an opportunity to discuss with Dr. Carroll the situation.

PRESIDENT PASCHAL: Criteria and guidelines for a comprehensive regional health care program in Appalachia—Mr. Barnes.

MR. BARNES: This is excerpted from material dated January 14th, 1966 dateline, Washington, D. C.

The Appalachian Regional Commission today adopted a set of criteria and guidelines to assist in the administration of the \$69 million health care

program under the Appalachian Region Development Act of 1965.

The criteria and guidelines were submitted to the Commission by the Appalachian Advisory Council, a 24 member committee of health experts appointed by the Commission to develop recommendations for a comprehensive regional health care program in Appalachia.

The Appalachian Regional Development Act of 1965 authorizes the expenditure of \$69 million of federal funds to be used with state funds for the construction operation of multi-county demonstration health centers in twelve state regions.

* * *

The appalachian program authorizes \$400 million for construction funds and \$28 million in operating funds for Appalachian Region Health Services.

The federal share for construction grants may not exceed 80 per cent. Operating grants may be up to 100 per cent in federal funds for the first two years and 50 per cent for the years thereafter.

The Health Advisory Committee headed by Dr. Paul A. Miller of West Virginia University will provide continuing advice and guidance to the Commission on Appalachian health matters.

This was directed to Dr. Paschal and the Council because this is an area of activity, undoubtedly, which is going to involve local physicians in areas of West and North Carolina and the thought was, you might want to give some consideration to having some people act for the Society.

DR. KOOMEN: We of course will desperately need the cooperation, and help and support of the physicians of the region and if this is best done by a committee of the Society, I would certainly welcome that.

PRESIDENT PASCHAL: Thank you.

Well, we'll accept this as information and pass on to item number twenty-four, under Old Business, (a) is a progress report on the DeBaKey Program on heart, cancer and stroke, which is actually Public Law 89-239.

I might give you the information that your representatives of the Medical Society and the three deans have continued meeting. An executive Committee has been appointed with the agreement of Governor Moore, for the participation of State Board of Health, Hospital Care Commission, and the State School of Public Health.

So they too are on this Executive Committee, or this steering committee.

This committee is to have a meeting next Wednesday—They are in the active process of trying to secure a first-class, able Executive Director who will have a long-range tenure, we think, if the plan is finally approved.

Possibly on Wednesday, they'll have some firm recommendation about an Executive Director.

(Mr. Barnes read a letter from Dr. Rachel Davis regarding progress in establishing a Department

of family living within the State Board of Health.)

PRESIDENT PASCHAL: You've heard this report from Dr. Davis. What is your pleasure?

Is there a motion that it be approved?

DR. BRIDGER: I so move.

DR. HARRY H. SUMMERLIN [Councilor, 5th District]: Seconded.

(The motion carried.)

Under item twenty-five, New Business, we have listed under (a) by-laws committee instructions relative to revisions on divers, non ad hoc, committees as to functional description and tenures.

This imposes quite a job on the Committee on Constitution and By-Laws. It has been felt that the function, scope and mission given to these committees would be helpful.

I don't know whether we want to take any definitive action on this at this time, or not.

DR. SHAFFNER: Mr. Chairman, as Chairman of the Constitution and By-Laws Committee, I would request that perhaps you let the By-Laws Committee delve into the problem think about it a little bit and then come back to the Council, without giving us orders to come up with anything, any particular recommendation or answer on proposed changes by the next meeting.

PRESIDENT PASCHAL: I think that's appropriate.

Without objection from the Council, why, we'll ask the Constitution and By-Laws Committee to do just that.

Concerning the Committee on Child Health with relation to the measles immunization program, Mr. Hilliard.

MR. WILLIAM N. HILLIARD: A meeting of the Child Health Committee was held in Durham, January 25.

The purpose of the meeting was a discussion of measles vaccine and the best method of increasing its use throughout the state.

After lengthy discussion, the committee recommended:

1. That members of the Medical Society of the of the State of North Carolina be more diligent in urging the use of measles vaccine in their practice.
2. That the measles vaccine furnished by the federal government be allocated to the various counties of the state on a population basis;
3. That there be a public education campaign by the State Health Department encouraging measles immunization for the childhood population in North Carolina and that the Medical Society of the State of North Carolina offer its endorsement and assistance to such a campaign;
4. That if the federal allocation is not sufficient to meet the needs of the indigent population, that state funds be made available to carry out this immunization;
5. That the State Board of Health in its publicity and educational campaign urge that children be

taken to their physician for measles immunization and that it be urged that those families without a physician secure the vaccine at their local health department.

PRESIDENT PASCHAL: You heard this report.

DR. GLASSON: I move it be approved.

(The motion carried.)

A message to me by Dr. Davis, a pathologist in Raleigh, from a communication he had with Don Morris who's the president of the North Carolina State Society of Pathologists and the message is this:

Happy with existing contracts of percentage arrangements. Not in agreement with position of AMA of College of American Pathologists.

As you know, the College and the American Medical Association have a different attitude about the billing of individual patients by pathologists in hospitals.

The 41 or 42 pathologists in North Carolina are members of the Society of Pathologists in this state and the opinion I read comes from their official spokesman.

One other thing I'd like to report to you is an action that I took in response to a letter from Meade Johnson Laboratories in which they state:

With the aim of sponsoring and encouraging the development of scientific exhibits of high quality Meade Johnson has created the "Aescudapias Award" designed as an award of excellence in concept and originance of scientific exhibits presentations at annual meetings of State Medical Associations.

Now, under the terms of this program, the most outstanding scientific exhibit is selected by a committee of the medical society and in our case it would be Scientific Exhibits Committee.

The author of the winning exhibit is presented with an appropriate certificate which is for the outstanding scientific exhibit and this is the "Aesculapas Award," and they propose to give with it a cash prize of \$200.

Now, I replied that the Medical Society of the State of North Carolina is pleased to accept their kind invitation to participate in this and that we would designate the Committee on Scientific Exhibits to be the judge of that procedure.

To further comment, the final program for the annual meeting has been completed.

Now, I have a letter from the president of the State Medical Society of Wisconsin in which they state they are in their 125th year.

One of the vigorous projects of the Society is the development of an active program of medical history and that is not bounded by any state or national line.

We would like to accumulate during this year letters of congratulations to the Society which may be permanently bound and placed in our headquarters at Madison. We would be most grateful to you if you would provide such a letter to be incorporated in this volume and would appreciate your sending it to the attention of our secretary.

Is there any objection that that be done?

DR. WILLIAMS: I move that that be done.

PRESIDENT PASCHAL: Mr. Barnes, I think, would like to comment on the current issue of the *Journal*.

MR. BARNES: Under the guide of the editorial board the decision was reached last September to change the auspices of the printing of the *North Carolina Medical Journal* effective with the January issue.

Now, this will be on your desks when you get back home and I would hope that at least the members of this Council would cast a critical eye on the quality of the printing and the reproduction of the ads in this January issue.

It has come out on schedule with the new printer after some difficulties of transition and we're on schedule for February and it looks like we're coming out probably around the 20th of the month.

DR. SHAFFNER: Mr. President, may I bring up a piece of new business for about thirty seconds?

PRESIDENT PASCHAL: Yes.

DR. SHAFFNER: As Councilor for the 8th District I have a problem.

We have, as you know, stopped having district meetings. Therefore, there is no organization of a district society.

The district society presently has \$300 in the bank.

We've been requested by, at least, Guilford County to prorate or refund the money to the societies who have contributed this money.

There is no officer of the district to make any decision except me and I would like approval of the Council to so do and also to ask Mr. Barnes to return to the counties any money that might have been collected as 8th District dues as many of them have, and I would so move that Council approve my doing that.

PRESIDENT PASCHAL: You've heard his motion. Is it seconded?

DR. WILLIAMS: Seconded.

(The motion carried.)

DR. BEDDINGFIELD: The Council has previously authorized as it has in the past, a trip to Washington in connection with the Chamber of Commerce thing, and you were all advised by letter from Mr. Barnes that the Chamber of Commerce public affairs conference was called off on somewhat short notice this year after we had made tentative plans to go.

And, we have had some inquiries from physicians from within our own membership, from AMA Washington office, and from two Congressmen about when are we going to Washington.

I would like to propose that the Council leave it up to the Legislative Committee to sponsor a journey to Washington at a cost not to exceed that already approved, at \$25 per person.

PRESIDENT PASCHAL: You've heard his motion. Is there a second?

DR. BRIDGER: Seconded.

(The motion carried.)

[The meeting adjourned at four-seven o'clock.]

SATURDAY MORNING SESSION

April 30, 1966

The regular annual meeting of the Executive Council of the Medical Society of the State of North Carolina held in the Grove Room of the Battery Park Hotel, Asheville, North Carolina, convened at 9:15 a.m., Dr. George W. Paschal, Jr., President of the Society, presiding. Dr. John L. McCain gave the invocation.

(Roll call.) (A quorum was declared present.) (On motion by Dr. Beddingfield reading of the minutes was dispensed with.)

(The motion was seconded by Dr. Williams.)

(The motion was put to a vote and carried.)

PRESIDENT PASCHAL: We will have the Executive Council report. Item 4, Report of the Executive Committee of the Council, the April 9th meeting.

MR. BARNES: That's been distributed to everybody.

Items 1 and 2 do require consideration. The first two items on this addendum agenda are instructions to the Headquarters Office with reference to dues to two members. The third item is the resolution of the Academy of General Practice, and the fourth item was the problem of the Attorney General's ruling with reference to the serving of alcoholic beverages, and I think sort of being adjusted in the interim.

Item 5 was the indication of the State Board of Health that the Governor had instructed the State Board of Health to write a plan for the administration of Title 19.

Number 6 was membership status of Annie V. Scott, and as a result of that, it was referred to the Councilor of the 8th District, and he has a report to the House of Delegates recommending her for Honorary Membership in the State Society, and that will come before the Council.

DR. EDGAR T. BEDDINGFIELD, JR.: Are you sure about Number 5? What you said and what you read?

MR. BARNES: Oh yes, that's in reference to the Relative Value Scale 1961. We had been requested by the Children's Department, which is the Division of Personal Health Services, to furnish them with copies of the 1961 Relative Value Scale, as they wanted to postulate a revision of their crippled children's fees based on that.

I had no authority to distribute that, and I took it to the Executive Committee, and they backed me in instructing the State Board of Health that they could not have the 1961 Relative Value Scale. They have been furnished, of course, with a 1965 adoption of the Relative Value Scale.

PRESIDENT PASCHAL: Number 7.

MRS. LARUE KING: That's the bulletins that are distributed quarterly to the State Board of Health. Anybody can get it if they want to get on the mailing list.

PRESIDENT PASCHAL: It was indicated that these things were available to anybody who wanted them on request.

We will go to Number 111. Referred to the Council with recommendations the request of Dr. Marianne

Breslin regarding the Medical Society's financial support for Symposium on Sexual Problems, May 21 and 22, 1966. She is a member of the Committee on Marriage Counselling.

MR. BARNES: I might say that this is a repeat program, more or less, sponsored by the Committee on Marriage Counselling to be held in May of this year, and last year the Council was called on for a special contribution to that, and it was voted.

Last summer, in the preparation of the budget, we communicated with Dr. Rachel Davis with reference to the need for funds in 1966, and for sometime we had no answer. And finally with a telephone call she indicated she did not contemplate any need for a budget this year.

So the Committee on Finance, when they reached that item in the fall, simply allocated a \$100 general allocation, which went into general committees, and that's the only fund that we have with authority to expend for this committee.

This program is coming up, and I understand that they have some drug houses that are helping with the sponsorship of it, but it's going to cost somewhere in the neighborhood of \$2,700, and they wanted about \$500 contribution from the Medical Society in support of that program. Of course, I have indicated the only thing I can do is bring it to the Council and get your authority.

The program last year was very well attended, and from all the evaluations that I have heard, it was a remarkable program, and the plans of the present practical committee for this year have worked out this program in considerable detail, and I think it would probably be a repeat type of undertaking.

I see no reason why the Councilors should not support it, having established the principle last year, but we can't pay out money we are not authorized to pay out.

DR. T. S. RAIKORD: Mr. President, before making a motion, I would just like to express this one view, that it is a dangerous precedent to let someone come up at the eleventh hour and ask for a specific amount of money. When they have gone through the regular channels, we have done all we could to try to get this, and we did not get a request until after the Finance Committee's report was made and the budget set up.

I think it might be well to give a token additional contribution or allocation, but I would not be in favor of the full \$500.

PRESIDENT PASCHAL: You have heard Dr. Raikord's remarks. Is there any other discussion or any motion about the action that we should take?

DR. MCCAIN: What about an alternative, one that would be participating up to \$500? If they need this much—sometimes they go over on these programs, and if they have an overage, we don't want to participate in any overage.

DR. BENTON: Couldn't you tell them that because it's not in the budget we could not authorize it this year, but we do support what they're doing; and if they are unable to carry on otherwise, we will

make every effort to bail them out up to \$500.

PRESIDENT PASCHAL: You have heard the suggestion of the Chairman of the Finance Committee. Is there a motion to the effect of what he said?

DR. HARRY H. SUMMERLIN: I make such a motion. (The motion was seconded by Dr. Bridger.)

PRESIDENT PASCHAL: It has been moved and seconded. Is there discussion?

All in favor please say "aye"; opposed, like sign. Carried.

For your information, I suppose all of you have this, but for those of you who don't, there's going to be a breakfast Tuesday morning at which Isadore Rubin is going to speak, and the subject will be "Sex for Breakfast."

DR. BEDDINGFIELD: Is the speaker a doctor of medicine?

MRS. KING: A Ph.D, Editor of Sexology Magazine.

DR. WILLIAMS: I note with interest that this magazine he is editor of is in the pornography section of the bus station newsstand, and I had a funny feeling inside when I discovered that and saw this program; but I will leave it there with no further comment.

DR. McCAIN: There is no endorsement, just because he's here on a program.

PRESIDENT PASCHAL: Not at all.

We will go to Item 8, Section (a), and ask for the Administration report by Dr. Benton.

DR. BENTON: Mr. President, I have no further report to make.

PRESIDENT PASCHAL: Secondly, under Item 6, sub-item (h), Editorial Board of the North Carolina Medical Journal. Dr. Nicholson is here, and he is Chairman of the Editorial Board, and we will ask him to give his report at this time.

DR. NICHOLSON: Dr. Paschal, Members of the Council: We had our annual meeting last evening. All were present except one.

Requests have come to our Editor several times about the publication of a biography, or a second obituary is what it amounts to, on some of the outstanding members of the Society who died during the past year. This essentially is writing two obituaries, and it becomes a little embarrassing to us at times.

So we recommend to the Council and to the Society that by some means, and in some way, a list of the deaths would be published monthly, or every two months, to be in alphabetical order, with a short sketch as to where they were born, where they practiced, and something about their contributions, not to exceed over three or four lines.

This is in keeping with the list of the deaths in the American Medical Association. I think it would save a great deal of embarrassment on everyone's part rather than to try to publish the obituaries as we have in the past.

The method by which these names will be obtained will be quite difficult, and we will have to put it on the basis of the local county society reporting to the Editorial Offices in Winston-Salem. I think that will demand a certain amount of legislation on the part

of the Society. I don't know that our committee can necessarily rule on this.

Another item for information is that the decision was made, and it has been set by precedent, to publish special numbers commemorating events or subjects, or people.

One Journal will be given over to the Robert A. Ross Obstetrics and Gynecological Society for publications commemorating Dr. Ross. This has been done in the case of Dr. Menzies, Dr. Davidson, and Dr. McKnight.

There will be a psychiatric edition at a later date too.

Dr. Graham's resignation was accepted by the Editorial Board members; Dr. Robert A. Ross was appointed to fill out his unexpired time, and we will, on Wednesday, nominate Dr. Ross for a new term of four years, and we will nominate Dr. Prichard for another four-year term. He, as you recall, is our Editor.

Mr. Barnes and Mr. Pace assure us that we are sound financially.

The last item. We were requested to publish the address of Dr. Leo Jenkins to the Guilford County Medical Society, and our decision was that until the Medical Society had formulated a policy and had approved or disapproved, we did not feel that we were, from the standpoint of the publication of the Society, able to publish such controversial subjects in the Journal as a lay person's address. This will not be published in the foreseeable future.

PRESIDENT PASCHAL: Thank you, Dr. Nicholson.

Are there questions that you would like to direct to Dr. Nicholson regarding his report?

MR. BARNES: I might make this inquiry of Dr. Nicholson.

With these special issues, it's usually an experience that they run much above the page quantity for that particular issue, and that these sponsoring organizations usually take care of the cost of the pages in excess of the normal rate of pages appearing in that particular issue.

DR. NICHOLSON: These individuals have been so informed, to get in touch with your office for the expense over that incurred in the publication of that particular issue. So they will meet all the expenses above that.

PRESIDENT PASCHAL: Any other questions? Is there a motion that the report be accepted?

(Such motion was made by Dr. Raper and seconded by Dr. McCain.)

PRESIDENT PASCHAL: Any further discussion? If not, all in favor please say "aye"; opposed like sign. Carried.

Now we will continue with Item 6, sub-item (a), and we will have a report from Dr. Schoenheit of the Committee on Constitution and By-laws.

DR. E. W. SCHOENHEIT: Mr. President, this report was to be presented by Dr. Shaffner who could not be here today, but will be here for the meeting of the House of Delegates. He asked me to make it for him, and I believe that you have copies of this in

your portfolio. It might be advisable to follow along, as some of these things are quite important, as I read it.

Report of the Committee on Constitution and By-Laws to the House of Delegates, May 1, 1966, Asheville, N. C.

This change was proposed and presented to the House of Delegates last year and along with the By-Law changes of last year will assure that only the active physician members of component county societies shall be the active members of the State Society.

Amend Article IV, Section 2 of the Constitution by inserting between the words "the members" the word "active."

The Section will then read:

"Active members of this Society shall be the active members of the component societies, and those physicians who are admitted by the Executive Council as hereinafter provided."

DR. STYRON: This needs some explanation. The change really means heretofore members could be taken into the Society when they were not taken into component societies. This means, I take it, that if the Executive Council votes a member into the Society, he then becomes a member of the component society; isn't that what it means?

PRESIDENT PASCHAL: No, I don't think so.

Mr. Anderson, do you want to speak to this?

MR. ANDERSON: "The active members of this Society" means it shall be composed of the active members of the component society. It doesn't mean an active member of the State Society shall be an active member of the component society.

DR. STYRON: I think you can get some argument on that in the way it's worded; I really do.

DR. RAIFORD: That's all I was going to say. I think the intent of the motion has been lost here. This was, in a sense, to take some of the component societies off the hook if for some reason or other they did not see fit to admit to active membership in the county society. That would not jeopardize their eligibility for active membership in the State Society. I think it is so worded there.

MR. ANDERSON: That's correct.

DR. RAIFORD: I think the wording is sufficiently clear, because it says "and those physicians approved by the Executive Council." It means if he is an associate member or member of a component medical society, the Executive Council can then approve him as an active member of the State Society.

DR. BEDDINGFIELD: I think it might help speed the action of the House of Delegates, and I would like to make a motion that Council endorse this change and recommend it to the House of Delegates.

PRESIDENT PASCHAL: You have heard Dr. Beddingfield's motion.

DR. RAIFORD: I'll second it.

PRESIDENT PASCHAL: It has been moved and seconded. Is there further discussion?

DR. FRANK W. JONES: Something that might be of a little interest. Under Section 5 of Chapter XV

of the county societies, it reads as follows: "These county societies shall be the judge of the qualifications of its own members, but said society to the portals of this Society and the AMA, only applicable and legally registered physicians who are practicing or will agree to practice nonsectarian medicine shall be admitted as active members."

Then an amendment "The county society must—may—admit other members on such basis of qualification as it may determine."

Doesn't that tie the whole picture into the word "active?"

PRESIDENT PASCHAL: I think it does.

Are you ready for the question? All in favor please say "aye"; opposed, like sign. Carried.

Dr. Schoenheit, will you proceed?

DR. SCHOENHEIT: We now come to a change in the By-Laws:

These proposed changes are presented today but must lay on the table one day (until the meeting Tuesday, May 3) before a final vote is taken, a majority vote being required for passage. Item 1:

Amend Chapter VI, Section of the By-Laws by changing the words "Assistant Executive Secretary" changes the wording to make it consistent with other to "Assistant Executive Director." This merely wording in the section describing the duties of the Executive Director and his assistant.

Item 2: The Secretary of the Society and each of the Councilors and Vice-Councilors are elected for terms of three years. Provision has been made that the Vice-Councilor shall succeed to the office of Councilor should the incumbent Councilor for any reason be removed from office. No provision has heretofore been made to fill any vacancy in the offices of Secretary or of any of the Vice-Councilors should it occur between meetings of the House of Delegates, nor more often than every three years.

The following three proposed changes would empower the Executive Council to fill any such vacancies until the next meeting of the House of Delegates and would instruct the Committee on Nominations to submit to that next meeting of the House of Delegates names of nominees to fill the unexpired terms of those vacant offices.

Amend Chapter V, Section 2 by adding to the last sentence so that it will read:

"The nominations for the ten (district) Councilors and ten (district) Vice-Councilors, and the Secretary shall be made each third year, except that nominations shall be made in any year as necessary to fill the unexpired terms of any such offices that may have become vacant since the last meeting of the House of Delegates."

Amend Chapter VI, Section 4 by adding this sentence:

"In the case of death or removal of the Secretary, the Executive Council shall appoint an Acting Secretary to serve until the next meeting of the House of Delegates, at which time the House shall elect an eligible member to fill the unexpired portion of the term of Secretary."

Amend Chapter VIII, Section 1 by adding the following:

"Upon the death, resignation, or removal of a Vice-Councilor, or upon his succession to the office of Councilor, the Executive Council shall appoint an Acting Vice-Councilor to serve until the next meeting of the House of Delegates, at which time the House shall elect an eligible member to fill the unexpired portion of the term of the Vice-Councilor. If an acting Vice-Councilor succeeds to the office of Councilor he shall serve in like manner until the next meeting of the House of Delegates."

Item 3: The Insurance Industry Liaison Committee has been an active working committee of the Society since 1959, but it has to date had no standing committee status, being appointed from year to year at the pleasure of the president. Because of the increasing importance of such a committee in representing the Society and its individual members to the various health insurance companies, it is recommended that it be given standing committee status in the By-Laws

The following changes are therefore recommended:

Amend Chapter X, Section 2 by inserting the following in the list of standing committees:

"A committee on Insurance Industry," and further

Amend Chapter X by adding a new section:

"Section 21: A Committee on Insurance Industry, appointed by the president, shall consist of a chairman and at least fifteen members representing as well as possible all geographic areas of the State and all subdivisions of medical practice. It shall be the purpose and the duty of this committee, subject to the authority of the Executive Council and the House of Delegates, to represent and act for the Society in all matters affecting the relationship of the Society and its membership with all commercial health insurance companies. It may organize itself into as many subcommittees as necessary for its functions, and one of these shall be the Medical Section of the North Carolina Insurance Claims Review Service.

The actions of this committee shall not usurp the functions of other committees of the Society as herein provided, upon request of any such committee and with approval of the president, this committee may assume such overlapping duties and functions as may involve the commercial health insurance companies. The committee shall present and promote to the health insurance industry the viewpoint of medicine on matters involving the two disciplines and shall effect a continuous liaison with the industry in matters relating the best interests of the public.

Your Constitution and By-Laws Committee has considered a recommendation that the continuous tenure of a member on any specific committee be limited to a specified number of years, so that the work of the Society may be shared by more members. While recognizing the merits of this proposal, your committee also sees that experienced, knowledgeable, and interested members might thereby be forced off

a committee at a time they can and are willing to contribute much. A blanket limitation on tenure could be a detriment to good committee function. Except as specifically provided in the By-Laws, the president has the prerogative of appointing committee members each year, and it would appear to your committee that the president should have the opportunity to change or retain committee members as would best serve the Society. We, therefore, do not recommend any limitation on tenure at this time, but would encourage comments from delegates and the membership at large for future consideration.

PRESIDENT PASCHAL: Thank you very much, Dr. Schoenheit.

You have heard this report and the recommendations, and the proposals. Is there a motion that these be accepted?

(A motion of acceptance was made by Dr. Duck and seconded by Dr. Summerlin.)

PRESIDENT PASCHAL: Discussion?

DR. MCCAIN: In a questionnaire that was sent out this year regarding the formation of new committees for next year, there was a comment about whether you thought, whether the Chairman of the Committee felt that this committee should have standing committee status. I was wondering if that would be—later on, if this is adopted today, would there be some further consideration of this? Maybe there would be a number of committees on this, involved in this, to be brought in together at one time.

I wonder what Dr. Jones would have to say.

DR. JONES: Am I permitted to speak to that?

PRESIDENT PASCHAL: Will you please?

DR. JONES: The questionnaire was sent to all committee chairmen of Dr. Paschal's administration more to get information for the President-elect than anything else.

The question at the top "Was your committee Constitution provided? y-Laws provided? Did it have standing committee status? There were actually thirteen standing committees in the Society. There were some listed in the By-Laws that do not have standing committee status.

Now in direct answer to your question, this possibly could be an opening to a re-evaluation of which committee should have standing committee status.

PRESIDENT PASCHAL: Is there further discussion?

MR. BARNES: I might say with reference to this final paragraph in the report, Mr. President, about the involvement of the membership, that we were interested sometime ago in making a tally, and that there are some 700 positions in the State Society involving the membership. We were a little bit amazed at that.

PRESIDENT PASCHAL: That's a fairly sizable representation.

Is there any further discussion on this point?

If not, are you ready for the question? All in favor please say "aye"; opposed, like sign. Carried.

Now this concludes Dr. Schoenheit's report.

DR. BEDDINGFIELD: May I raise one thing, since the report has been voted on?

We have discussed for many years, in the work of the Constitution and By-Laws Committee, the directive from the State Society that county societies Constitution and By-Laws with the State Society, and unless I am mistaken, probably less than half of the component county societies have on file in the headquarters office a copy of their Constitution and By-Laws.

I think that this might become very important with the change and complexion of our membership. I could even conceive a situation whereby if some legal action might come up at times against the county society who didn't choose to admit all members, that the State Society not be a party to such a legal action unwillingly.

I believe that we ought to do everything that we can in the leadership of the State Society to see that each county society has an updated Constitution and By-Laws that they understand.

I believe the leadership could properly be provided by our Committee on Constitution and By-Laws, perhaps to the extent of compiling a model, suggested draft of a component county constitution and by-laws, send it to those who do not have it, and ask them to act on it, modify it anyway they want to, and return it to State Society headquarters. I believe this

PRESIDENT PASCHAL: We would urge that the Committee on Constitution and By-Laws explain this to the various county societies and urge their cooperation.

PRESIDENT PASCHAL: It has come to my attention through the Speaker of the House of Delegates that we have actually been out of order in the election of members to the Board of Medical Examiners, and possibly to other boards in the past few years, in that this election has been held in the third general session.

I will ask Mr. Barnes to read the section that designates the time of election for these people, and we'll talk about it further after that.

MR. BARNES: Article IX, Section 1. The election shall be held on the second day of the annual meeting, and the balloting shall continue until the required number is elected."

Then Section 3: "The seven elected members of the Editorial Board of the North Carolina Medical Journal shall be elected by ballot in the second general session at the annual meeting as follows: Three for a period of four years, two for a period of three years, and two for a period of two years. The balloting shall continue until the entire number is elected"

The problem, if I may comment, is that this was written many years ago, and I will first say that during those years after it was written, the Society had two may become very important to us at some foreseeable time in the future.

general sessions, the first and the second. Usually the House of Delegates met on Monday, and the first general session was on Tuesday, and the second general session was on Wednesday.

About 1961, this was changed to establish a general session for Monday, and the Committee on Scientific Works in designing the program labeled Monday

as the first general session, Tuesday as the second, and Wednesday as the third; and the staff had always assumed that you elected them at the final general session, and so the elections have been held each election year that these two boards were involved on Wednesday, rather than on Tuesday, which is the second meeting of the general sessions.

PRESIDENT PASCHAL: This year they are scheduled to be elected on the same day. We have not been complying with the letter of the law, so to speak, but I wanted to bring this to the Council, and I believe it would be in order to, at this time, have the Committee on Constitution and By-Laws submit a change that would rectify this, and that it would be considered at this present meeting as well.

MR. BARNES: Since they are Articles, it would take a year to do it.

PRESIDENT PASCHAL: It would be presented this year and lie over for a required time.

DR. RAIFORD: Mr. President, I would therefore move that the Council recommend to the Constitution and By-Laws Committee to make two changes in Article IX, Section 1 and in Section 3. Change "second day" to "last day." This is a recommendation to the Constitution and By-Laws Committee.

(The motion was seconded by Dr. Bridger.)

Is there any further discussion? I just wanted to be in a position of trying to conform to the Constitution and By-Laws, and I was aware that we were out of order.

Are you ready for the question? All in favor of Dr. Raiford's motion let it be known by saying "aye"; opposed, like sign. Carried.

MR. ANDERSON: If you wanted to, Mr. President you could just call for a motion to postpone the election, suspend the By-laws on Tuesday, and have the election Wednesday as published, and then nobody would raise any question about it.

PRESIDENT PASCHAL: We'll go back to Item No. 4, subsection III, item No. (2), which has to do with the Committee on Headquarters Facility.

MR. BARNES: I don't believe Dr. Rose is here.

PRESIDENT PASCHAL: I talked with Dr. Hewitt Rose last night by phone, and he gave me information which Mr. Anderson also has with him.

The Committee on Headquarters Facility has met on at least two occasions recently to consider the acquisition of certain property for a headquarters facility.

As was brought to the attention of the Executive Committee at their last meeting, we talked to the Headquarters Facility Committee about the property on which we hold an option. Explorations have been made about this matter. Consultations have been carried on with those who know what the state's plans are, and we are informed that the property which we do have an option on is in an area which the state plans eventually to utilize, and they have been authorized to make acquisition of this property eventually, when it might become available.

My own investigation led me to understand that this property might not be used for forty years, it might

not even be used for 75 years. But they did intend to incorporate this in the area of the so-called Heritage Square.

There is some possibility that—we had no assurance from them, I might say, that if we did acquire this property and did institute some building program on it, that no condemnation proceedings would be forthcoming. We don't get this assurance, so the Committee began looking for alternate sites, and on the 24th of this month, just last Sunday, they did meet.

Dr. Webb and Dr. Elias Faison met with Dr. Rose, and Mr. Barnes met with them, and Mr. Anderson. They spent some four to six hours looking over properties and the committee does have a recommendation, and I'm going to ask Mr. Anderson to pick up where I had left off and bring further information to the Council about this matter.

MR. ANDERSON: Mr. President, the Committee's recommendation regarding the disposition of the property on which we hold an option was to report to the Council and the House of Delegates, through you, the situation regarding the state's plans, which is that the acquisition was formally authorized, presumably at the price we have paid for it, plus any expenses, I would assume. The authorization was to acquire it for \$5,000, plus paying another \$85,000 to the seller.

The Committee's feeling about that proposition, whether or not we attempt to retain this property or whether or not we attempt to retain any additional price other than that which we would pay for it from the state, the feeling was that we are not in a very good bargaining position, and we're practically stuck with going along with what the state wants to do.

Their feeling was that it would be not wise to formulate any firm plans to build and run the risk of having the commission recommend that the state acquire the property by condemnation, feeling that members of the commission in their duty to the state would be forced to use whatever means the state may have at their disposal to acquire the property before a several hundred thousand dollar building were put on the property, which would involve the state paying for the building in future years.

Secondly, the committee did not feel that due to all the circumstances, that they would recommend that the Society attempt to make a profit on the land sale, or the option sale.

Then after considering all the sites available in Raleigh, the Committee—the majority of the Committee—recommended that the Society acquire a tract of land which is now known as the Mordecai Property, located on Wake Forest Road in Raleigh.

PRESIDENT PASCHAL: That's an old homesite. The house on it is over a hundred years old consisting of an entire block, 400 x 300 feet approximately. It has an old home on it with some other tenant houses on it. It's wooded. It has trees, shrubbery, a beautiful place. It sits high from the surrounding land. It's not zoned for anything except residential purposes now. It would be available subject to rezoning for purposes of building a headquarters building, or so-called institutional classification by the City Council.

The neighbors who have been contacted by Mr. Mordecai, who is an attorney and relative of the owner, Mr. Burke Little, who is now 84 years old and resides in a nursing home in Raleigh, but who is mentally competent—Mr. Mordecai's inquiry, some limited inquiry of the neighbors, reveals that there would be no serious objections from the neighbors, who would be in a position to object to such rezoning.

The price stated by the seller was \$100,000 at first, and then after some discussions, the Committee wondered whether that price would hold up. Mr. Mordecai indicated that he would have to have it appraised by a real estate appraiser, and the Committee of Dr. Rose and Dr. Elias Faison said "We'll never get it for that price."

But on Thursday and Wednesday of last week, I had a discussion with Mr. Mordecai and told him that unless something concrete and in writing were given to us to present to the meeting this weekend, this Society might go ahead and purchase another site.

So as a result of all the discussions, Mr. Mordecai delivered to me yesterday a written option for the sale of the property for \$100,000 to the Medical Society. It's not assignable, George. So that's open. The offer will be open until November 1, 1966, but not thereafter. We didn't feel that we could ask him to hold it open any longer than six months.

What I hold in my hand is a firm option under seal for the sale of the property for \$100,000 cash, or \$30,000 cash, balance in 7 annual payments of \$10,000 each. Mr. Mordecai and I discussed varying those terms, and I told him that I would recommend that if the Society purchased it, the Society adjust the terms to suit the tax advantages of Mr. Little to whatever extent necessary.

So the Committee recommended the purchase of this property.

Would you want to go into the discussion of any of the other available tracts?

PRESIDENT PASCHAL: Let me speak to this just a moment.

I said Dr. Rose did call me last night and gave me the recommendation of his Committee. I would point out that this property is situated on Wake Forest Road, which as John told you is a continuation of Person Street. That's the street on one side. The other is Mordecai Drive, and the street to the north of that is Cedar Street, and I don't remember the other little street.

MR. ANDERSON: Mimosa Street.

PRESIDENT PASCHAL: This property is 8/10ths of a mile from the State House. It is approximately something more than four acres, I believe. These houses that are on their. I don't believe would be usable, although there is some fine timber in the old building.

The other properties that were looked at, some ten or twelve of them, some were adequate and some were inadequate. The one that was given further consideration was one on Person Street directly to the east of the Governor's mansion, right across the street from the Governor's mansion.

This piece of property had 48,000 square feet.

The pricetag on that was \$175,000. This property,

the Mordecai Property, is situated in a desirable area. It would lend itself, I think, to any building that we want to do. It would afford us ample parking facilities and space, and let us expand if we so desire, and it was the recommendation of the committee that this property be bought and used for a headquarters facility.

DR. BRIDGER: How much more land do you have there than the original place near the State House?

PRESIDENT PASCHAL: It's about four times as much, I would say.

I might say that the \$5,000 option that we have on the property within Heritage Square will be taken up by the state, and they have proper authorization even now to go ahead and pick up our option, so that we will lose nothing on that.

Would someone like to make a motion that the committee's recommendation be accepted?

DR. BRIDGER: I will make such a motion. I think I know where that property is.

PRESIDENT PASCHAL: You have heard Dr. Bridger's motion; that is, approve the recommendation of the Headquarters Facility Committee.

(The motion was seconded by Dr. Raiford.)

Any further discussion?

DR. McCAIN: In the earlier site, one of the desirabilities of that you didn't have to get in your car to go to the State House. But I understand this 8/10ths of a mile, it may be necessary to get into your car.

DR. RHODES: It's not over eight blocks at the outside from the State House.

DR. McCAIN: One of the things about the accessibility to road arteries, if it's really close to the State House, why that would be fine; but if you had to get in your car, it might give more importance to accessibility to main arteries as a meeting site for physicians outside the area.

PRESIDENT PASCHAL: It's accessible. It's not difficult to get to. It has better parking facilities than any place that we could have.

DR. BENTON: And the closer you get to the State House the better chance for taking it over too.

PRESIDENT PASCHAL: Certainly it's within the area which they call Heritage Square.

Is there further discussion? John, do you have anything else you want to say to this?

MR. ANDERSON: No, sir. All of the other properties in Raleigh the Committee looked at, except one, the \$175,000 tract behind the Governor's Mansion, were either so expensive or so small, around 30,000 feet, as to make it undesirable in the Committee's judgment.

We tried to get the state to consider some possibility of swapping, and the state—Mr. Turner representing the state—indicated that they would be very happy to try to arrange a swap, but they had no property available except some property which is on the boulevard right off Glenwood Avenue, which Jim and I investigated. The Committee didn't choose to look at it. That was not feasible or practical for building purposes, such as you would desire.

PRESIDENT PASCHAL: All right. Mr. Barnes, you were with the committee; do you have anything you would like to say?

MR. BARNES: I don't believe so, Dr. Paschal. I think the location of this property is relatively close to the present state complex, and of course as the Heritage Square is developed, it's going to be more and more so, because it's actually less than two blocks from the eventuality of the Heritage Square development. Of course, that may be 50 or 70 years, so I shouldn't be worrying about that individually.

I think that outside of this \$175,000 piece of property that you're not going to get property any closer to the state complex of offices. It would be relatively as close to the Post Office as the other site that we have the option would be when the new Post Office is built.

PRESIDENT PASCHAL: There is a Mordecai Street Post Office just within two blocks of the property.

MR. BARNES: I think that in commuting from the Headquarters Office to any state department, or the legislature, or capitol, or what have you, that there would be just a little bit too much distance for legwork, and one staff member is going to have to push another one up to where his appointments are, particularly in rainy weather. But doing a lot of dancing and a lot of walking, eight blocks is not much problem for me, even at my age.

PRESIDENT PASCHAL: Are you ready for the question?

All in favor please say "aye"; opposed, like sign. Carried.

I think we're lucky, and we've got something that is worth twice as much.

Going to Item (3), consideration of naming a committee to work with Pilot Life Insurance Company in the administration of Part "B" of Medicare (Pilot carrier for one year). Establish committee representing different segments—surgery, pediatrics, internal medicine, and so forth, primarily charged with liaison between Medical Society and Pilot with implementation of the law.

Now the Executive Committee recommends to approve representatives from the Insurance Industry Committee to go to Pilot and report back to Council with recommendation as to each function.

Dr. Jones, I believe, has contacted them, made some contact with them, and has carried out the recommendations of the Executive Committee. This will proceed further as time goes along, and we bring this to you for information, and I will ask Dr. Jones if he has any comment.

DR. JONES: Mr. President, the Executive Committee did, at a recent meeting in Raleigh, direct the undersigned to state to the Insurance Committee that they should formulate a plan, working as a Medical Society Committee in the area of Public Law 89-97, Part B.

The suggestion was made at first that an entirely new committee be formed, and later this was modified to suggest that a subsection or subcommittee of the existing committee be designated for this function.

It was indicated that a proposal of operation submitted by the Insurance Industry Committee would be brought to the Executive Council and that depending upon their approval the Insurance Industry Committee

would be designated as having this assignment "at least for the time being."

The Insurance Industry Committee did meet, and after many hours of thought and deliberation, the perusal of the Act itself, the advice of all the members, of the Committee present, and probing with representatives of Pilot, came up with the following statement:

The Insurance Industry Committee of The Medical Society of the State of North Carolina will be most pleased to act in the area of Public Law 89-97, Part B, and will work with the Medicare fiscal intermediary (carrier) in the same fair and unprejudiced manner that it has functioned in regard to other previously handled health insurance matters.

Should the Executive Council designate this Committee and any subdivisions as may be necessary to work with the carrier for Part B of Public Law 89-97, the experience developed as a result of seven years of deliberations in the health insurance field, including "claim review" function, is considered to be of incalculable value with reference to the public interest and to the interest of all parties concerned in the implementation of Public Law 89-97.

Further, it would be the intent of this Committee to call upon other committees of The Medical Society for consultation where the need for their advice and counsel becomes apparent. This Committee will continue to represent the proper interests of the medical profession at all times.

This Committee agrees it is advisable to enlarge the membership of the Committee to include the specialties of medical practice. Other than for enlargement of the membership, this Committee feels, at this time, there should be no different or otherwise separate method of handling Public Law 89-97 matter than in handling any other health insurance matter. This will insure consistent and equitable perspective regarding all health insurance situations brought to consideration.

There is no reason that government confrontation would make this Committee any less staunch in its attitude with reference to the public interest, the interest of our patients, and the interests of The Medical Society of the State of North Carolina.

This was very carefully recorded, Mr. President, based upon the attitudes that have been presented over the country by various organizations, by state societies, by government people. This undoubtedly will be a statement that would be accessible to the public. It is therefore wise that we put ourselves in a position of not being painted into a corner, so that we may move in any direction that we want. We have emphasized the attitude generally of the Society.

Now in addition to this, we have some information which is not a formal presentation to this Society from the carrier, but is the gist of the remarks made by the carrier as it applies to any posture that they might take with reference to being the carrier at this time.

For over 18 years, this particular organization states that they have experimented with the health insurance benefits paid under the reasonable and cus-

tomary concept. Literally millions of claims have been based upon reasonable and customary fees and thus far no rigid guidelines have been required to control claims cost.

The industry has discovered in the study of a million claims paid under reasonable and customary that 99.6 per cent were paid according to the doctor's original insurance. It has worked well because insurance has not assumed the obligation of controlling medical care costs, but is interested only in avoiding abusive claims in establishing premiums at a level sufficient to cover claim costs.

They go on to say that they feel that they must prevent premium increases necessitated by careless claims administration.

It is the opinion of the companies that the development of individual physician's profiles at this time with the expectation of controlling Medicare claims would necessarily result in an immediate escalation which would be to the disadvantage of the public and lead ultimately to the disadvantage of the physicians.

For this reason, the industry has been adamant, and I'm sure that this was done, in urging the Social Security Administration to withdraw its request that these individual profiles be obtained at this time.

The industry proposes that it be permitted to follow the usual system of reasonable and customary fee determinations used in other health insurance. Relative Value Scales are useful as a rough guide in determining reasonable and customary fees. Depending upon the level of practice of the physician concerned including specialty certification, hospital and teaching appointments and geographical location, a rough estimate of an appropriate conversion factor for use with the Relative Value Schedule can be determined. If the fee determined by the use of the Relative Value Schedule with an appropriate conversion factor is within acceptable limits, no further investigation should be necessary and the claim should be paid. If the fee submitted is higher, then it should have additional investigation to determine whether any unusual circumstances, such as complications, special services, or other extenuating situations which would indicate a greater than usual fee. It should be questioned only if it is greater than the usual level of charges of other physicians or similar training and ability with patients of similar circumstances in the same geographic area.

The Social Security Administration is considerably concerned that fees not only be reasonable, but also customary. There is considerable apprehension that the advent of Medicare will be similar to the experience of companies when major medical insurance was first devised to provide reimbursement based upon reasonable and customary charges.

In these early days, there was generally some abuse of major medical; but as it strung itself out, there is practically no abuse under major medical now. I think the Claim Review Service can show this very clearly.

It appears that charges of physicians to patients insured under major medical is essentially the same

as to all other patients. If Medicare is subjected to the same abuses which major medical insurance received initially, it is almost certain the Social Security Administration will be obligated to establish rigid controls which will not be to the liking of either the carriers or physicians. Insurance carriers hope that physicians' familiarity with major medical insurance will permit them to treat Medicare exactly as they would any other insurance program and thus avoid the necessity of rigid governmental guidelines for the determination of reasonable and customary fees.

One other point should be mentioned, and that is that any carrier that is going to be forced to start keeping, if they do not already have (most of them have) a profile—but at this time it is my understanding that the industry has prevailed upon HEW not to make it mandatory that they have a prior profile on each individual physician.

That generally is the thinking of the Insurance Industry Committee. One, the committee will handle it, if it is designated to do it, and will expand its committee; but in view of the ramifications and the position in which medicine will be, it is better not to paint ourselves, as I have said, into a corner, or box ourselves in, if we cannot move in a fluid way if it becomes necessary.

PRESIDENT PASCHAL: Thank you, Dr. Jones.

You have heard the comments of Dr. Jones regarding this matter. Are there any questions?

DR. BEDDINFIELD: The Advisory Committee from the American Medical Association on Public Law 89-97 has objected to some of the proposals of the Social Security Administration in setting up physician profiles, as Dr. Jones indicated. There has even been implication that individual physician's fiscal records might be subjected to scrutiny in order to obtain a profile of their charges, and I am sure, but I would like to reiterate it would be my thinking—and I think the thinking of this Council—that this committee exert every influence it has with the Pilot Company, where it is an intermediate carrier, that such indignities not be imposed upon the physicians of this state.

PRESIDENT PASCHAL: I think we should bend our influence to resisting this sort of thing.

Is there a motion that we approve the recommendation, that we approve representatives from the Insurance Industry Committee to go to Pilot and report back to us periodically? I don't know that we need that specifically.

(Such a motion was made by Dr. Welton, seconded by Dr. Murphy, put to a vote and carried.)

The Executive Committee agreed and recommended that—agreed with the suggestion of Dr. Raiford that the mileage rate be changed from seven to ten cents per mile, and we would pass this on to the Finance Committee with the hope that they might approve it, the change in voucher forms, and he also wanted to recommend that officers' expenses be paid for national meetings.

Dr. Raiford, do you want to speak further on this?

DR. RAIFORD: My feeling on this—and I purposely waited until I'm about to become a past-president

so I could not be accused of having any financial interest in it—is that seven cents a mile is not a very realistic figure. It may have been 25 years ago, but it's not now, and ten cents a mile is the average allowance for Governmental employees and is fairly well accepted the country over.

As regards the second one, our recommendation was simply this: That when officers or representatives of the Society were requested by the President or the Executive Committee to attend certain functions, that the President and the Executive Director be authorized to pay their expenses.

PRESIDENT PASCHAL: Is there a motion?

DR. KERNODLE: As Past President, I would like to speak in behalf of this, and I don't think it has to go to the House of Delegates. I think this is an administrative affair of cost of operation. I know that this was no problem as far as designating some one to cover a meeting. There was always money available to pay their expenses.

I think what Ted wants to do is make it an official action of the Council as an administrative effort, and it doesn't have to go to the House of Delegates at all.

The interest is that the State Board of Health gives them a per diem, plus the ten cents or eight cents; or the State of North Carolina gives a per diem. So I would say that I think you would have the authority in this body to move on this and never take it before the House of Delegates. It's administrative action.

PRESIDENT PASCHAL: Let's take up the first one regarding the mileage allowance.

I would think there would be some advantage to have this in a flexible situation, so that if the mileage is obviously—if even ten cents a mile would be too little—that the administration would have authority to authorize the going rate, whatever that might be.

Do I hear a motion that we approve the increase in the mileage allowance to a reasonable ongoing figure?

DR. GLASSON: I move that it be done.

(The motion was seconded by Dr. Bridger.)

PRESIDENT PASCHAL: Is there discussion? If not, all in favor say "aye" please; opposed? Like sign. Carried.

DR. BENTON: While you're on the subject of finance, one thing I would like to get Council thinking on, a little bit more on finance, is that on this \$100,000 land that we're going to buy—personally, I'd rather sell our stocks and bonds to pay for that thing rather than sell our land on the Durham-Raleigh Highway.

One reason: Our invested mutual from June 26, 1962 until January 28, 1966, has only raised 32.8 per cent during that time, and our land has increased in value far more than that; and in view of the present political situation, and so forth, it seems to me that we would be much wiser to use our stock to buy this new land, rather than sell at a high point.

I would like for them to think about it and let me know their thinking before that comes up. Jim says we're going to have to have a commitment from you all on that land to me before we can sell it anyway. Think long and hard about what you want.

PRESIDENT PASCHAL: Thank you.

Are we committed to turning this over to the man that gave us the option, the agent?

MR. ANDERSON: I think it would be well to authorize the officers to release the option to the State by a formal motion right now to clear that up.

PRESIDENT PASCHAL: The property on which we now hold a \$5,000 option. To release it for what we have in it.

DR. BEDDINGFIELD: So moved.

(The motion was seconded by Dr. Bridger.)

PRESIDENT PASCHAL: Is there discussion? If not, all in favor say "aye"; opposed, like sign. Carried.

PRESIDENT PASCHAL: All right, we did not complete item (c) with particular reference to the expenses of officers at the national meetings.

Do you want to take any action on that at this time?

DR. WELTON: I would move any officer or other representative designated by the President or Secretary have his expenses paid.

(The motion was seconded by Dr. Romm.)

DR. GLASSON: Mr. President, I might point out that one of the things brought up by Durham-Orange County in the motion written up by Dr. Hughes was that the members of the Society were spending too much money out of their own pockets for the Society, and this would tend to support their views.

PRESIDENT PASCHAL: Are you ready for the question? All in favor say "aye"; opposed like sign. Carried.

Now one other thing that the Executive Committee did was to consider a change of name of the Grievance Committee to the Committee on Mediation, which was proposed by Dr. Raiford, and I think that the idea came to him from his attendance at the First National Congress on Ethics, which was held in Chicago earlier this year.

DR. RAIFORD: Mr. President, as you said, this was the first National Conference on Medical Ethics, and it was quite obvious during this session that the various states were trying to get a uniform statement of dealing with complaints against the profession and organized medicine.

Several states have come up with the idea that it is far better to call this a Committee on Mediation, rather than a Committee on Grievance, and to not publicize it as a clearing house for grievances. You're simply inviting trouble. But this is a Committee on Mediation, and not arbitration, mind you, because arbitration implies disciplinary action. This is a committee on Mediation to try to settle amicably differences of opinion between the lay public and members of the profession.

I would therefore move to recommend to the Committee on Constitution and By-Laws that this be done, and changes made in the Constitution where necessary.

PRESIDENT PASCHAL: You have heard Dr. Raiford's motion. Is there a second?

(The motion was seconded by Dr. McCain.)

PRESIDENT PASCHAL: Are you now ready for the question? All in favor say "aye"; opposed like sign. Carried.

DR. RAIFORD: If I might just bring for information the latter part of that, number three: You will find in your folders this blue sheet entitled "Modus Operandi for the Grievance Committee," or since this motion has passed, the Committee on Mediation. This is simply brought for information, and it is an attempt to formulate in a uniform manner how the past five presidents, which comprise the present Committee on Grievances, proceed with their management of any complaint. There is no action taken; it is within the province of this committee.

However, I do want to point out one thing, as you will notice in the last of this, and that has to do with the maintenance of records of any case brought before this committee.

We had quite a bit of discussion about this, what was done with the records. It varied all the way from immediate destroying of the records in some states to publishing them in the transactions in Connecticut.

Now we felt this way: We have to have some reference to cases which are ostensibly settled, but which have a habit of rearing their heads once in a while. The central office should know where those files are. So we propose that the current secretary keep in his possession for as long as he wishes to, three or four years, statute of limitations, any records on cases which have been successfully concluded during his tenure of office; that he pass on any incomplete files to the succeeding secretary, and that at the end of his year, his tenure of office, he submit to the headquarters office a list of the actions taken without specifics.

PRESIDENT PASCHAL: Dr. Raiford, I have the impression that if this is going to be something we're going to pass on to future committees, that it might be well for the Executive Council to take action on this.

DR. AMOS JOHNSON: I think credit should be given where credit is due, and I want all of you to know that Dr. Raiford this year has given more thought, more constructive thought, and has worked more diligently to make of this Grievance Committee this year an effective arm of the State Medical Society.

He has come up with the recommendations that you have heard here, but over and above that, he has handled some most difficult cases in a manner reflecting credit on the Medical Society of the State, and on us as doctors, and I wanted him to hear me tell you all that I have been aware of this, and that he has made this year a success, and he really has done an excellent job. All of this comes from the product of his labors and his thought.

PRESIDENT PASCHAL: The Executive Committee was aware of his accomplishments, after having discussions about this matter. What is your pleasure?

DR. KERNODLE: I would like to go one step further and ask, once these records are completed on them, if they should be maintained at all in the State Office. It says here kept on permanent file in the headquarters office.

DR. RAIFORD: I'm talking about this report, the report simply by name and complaint, so that this does not give any of the confidential information whatsoever,

simply the date it was received, the date it was closed, who the involved parties were, the accused and the aggrieved, and the action taken, and the disposition of the case.

MR. ANDERSON: That would not be used by anybody in litigation.

DR. RAIFORD: Jim Barnes would know who has the file on any specific case, should that come up again.

PRESIDENT PASCHAL: Motion?

(A motion to approve the recommendation was made by Dr. Duck and seconded by Dr. Jones.)

PRESIDENT PASCHAL: Any further discussion? If not, all in favor say "aye"; opposed, like sign. This is carried.

I think this would be a very helpful thing.

Now we move on to Item 5.

DR. STYRON: Mr. Chairman, before you move out of Item 4, I would like to ask Mr. Barnes whether it is reasonable to move up the deadline for committee reports.

MR. BARNES: The present requirement is March 1st, and on March 1st, we rarely ever have more than one or two reports. The usual excuse is that the activity year is very short by March 1st, and they can't encompass most of the work and activities of the committee in that period of time. I don't know what you accomplish by setting it at February 15th, but if you're going to change it, you ought to set it for us, so that we know what to try to hold them to.

DR. BEDDINGFIELD: I am probably more guilty than any other committee chairman in being late. I would like to point out that a good many committee functions—that is, the time of year that they occur, and if a committee report is to be meaningful, even though it is desirable for the delegates to have them in advance, if you have important transactions, for example, in legislation pending—for example, the state legislature doesn't convene until February, and it's slow getting off to a start, and you don't know what medical legislation is going to be introduced, and if you have to send a report in by February 15th, it would be completely meaningless on legislation by May. Do you see what I mean?

PRESIDENT PASCHAL: Item No. 5, Resolutions and Communications. Item (a), Rowan-Davie County Medical Society Resolution No. 10.

MR. BARNES: This is a directive to me from Dr. F. B. Spencer, President of the Rowan-Davie County Medical Society.

The Rowan-Davie County Medical Society at the regular February meeting voted unanimously to recommend to the Executive Council of the Medical Society of the State of North Carolina the following:

1. That we approve and subscribe the AMA Resolution of June 1965 with the following change in the wording of the first line—"It is recommended that whenever any government agency assumes financial responsibility for an individual's health care, reimbursement for professional services shall be on the same basis of other indispensable elements of health care. Therefore, reimbursement for the services of physicians participating in government supported

programs should be on the basis of usual and customary fees."

2. That the Society take immediate steps to abrogate and rescind all existing agreements with reference to negotiated professional charges and further that the Society withdraw its endorsement of all Service plans of insurance.

This is dated February 3, 1966, and signed by Dr. F. B. Spencer, Jr.

PRESIDENT PASCHAL: You have heard this reading by Mr. Barnes. What is your pleasure concerning this? This will be passed on to the House of Delegates for their consideration and action.

If there is a motion to send it to the House, that will take care of it.

(Such motion was made by Dr. Raiford and seconded by Dr. Murphy.)

PRESIDENT PASCHAL: Further discussion? If not, all in favor say "aye"; opposed like sign. Carried.

The same thing applies to Resolution No. 11. I will ask Mr. Barnes to read some information pertaining to this.

MR. BARNES: This is a resolution from the Committee on Nursing and Patient Care.

Whereas, the Driver's License Division of the North Carolina Department of Motor Vehicles, through the encouragement and advice of the Committee on Trauma of the American College of Surgeons, now includes on the state automobile driver's license space for providing certain medical information which is helpful to the holder in the event of emergency; and

Whereas, The importance of the medical information for which provision is made on these driver's licenses is recognized; now

THEREFORE, the members of the North Carolina Committee on Nursing and Patient Care commend the North Carolina Department of Motor Vehicles and the Committee on Trauma of the American College of Surgeons for this forward-looking step and recommends that every avenue be explored to acquaint drivers with the importance of completing the medical information form on their licenses; and

FURTHER suggest that the State's two Blue Cross Plans explore the feasibility of including similar medical information on membership cards; and

FURTHER suggests that the Medical Society of the State of North Carolina consider the possibility of setting in motion through the proper channels a request that similar medical information be included on identification cards to be issued to Medicare recipients.

PRESIDENT PASCHAL: You have heard the reading of this resolution. Is there a motion that this be approved?

DR. McCAIN: I recommend it.

PRESIDENT PASCHAL: Dr. McCain moves it be approved and sent to the House of Delegates.

(The motion was seconded by Dr. Bridger.)

PRESIDENT PASCHAL: All in favor of the motion let it be known by saying "aye"; opposed by like sign. This will be done.

Item (c) Buncombe County Medical Society—com-

pensation for physicians for medical care rendered welfare patients.

MR. BARNES: This comes in a letter directed to me under date of March 2nd from Dr. Luther E. Barnhardt, Jr., Secretary-Treasurer of the Buncombe County Medical Society, and the letter to which the resolution is attached—and I will read the resolution resolution concerning compensation for the care of welfare clients.

Whereas, clients of departments of public welfare are no longer either destitute or impoverished but are recipients of cash and other benefits from city, county, state and Federal agencies; and

Whereas, with the notable exception of the medical profession, all purveyors of goods and services to these aforementioned welfare clients expect reasonable compensation for their services; and

Whereas, the social and economic changes now taking place in our society point out the necessity for each physician to begin to protect the quality of the professional services rendered each patient by seeking an adequate recompense for his time and his effort and his ability;

BE IT THEREFORE RESOLVED, that the Medical Society of the State of North Carolina recommend to the various departments of public welfare that funds be provided in their budget to compensate physicians for the medical care rendered welfare clients with fees comparable to the usual and customary fees charged by the physicians in the community wherein they reside.

The resolution has been reproduced but not numbered, pending action of this Committee on whether it should go to the House of Delegates.

PRESIDENT PASCHAL: You have heard the reading of this resolution of the Buncombe County Medical Society. What is your pleasure?

DR. BEDDINGFIELD: Move it go to the House of Delegates.

PRESIDENT PASCHAL: It is seconded?

(The motion was seconded by Dr. Jones.)

PRESIDENT PASCHAL: Is there discussion? Are you ready for the question? All in favor let it be known by saying "aye"; opposed by like sign. Carried.

Now then, the next is a motion of the Durham-Orange County Medical Society, communicated through a letter by Dr. Jack Hughes.

MR. BARNES: This is a letter dated April 18, 1966, directed to Dr. George W. Paschal, Jr.

Dear Dr. Paschal:

On many occasions in recent years various physicians throughout the State have pointed out that an enormous amount of physician time, energy and out of pocket cash (apart from annual dues) are expended in carrying on the activities of the State Medical Society. Also, that at least in some areas the results produced do not appear to be worth these expenditures. Two of the more frequently given examples are the scientific exhibits and scientific programs at the Society's annual meeting.

The Durham-Orange County Medical Society has

taken note of these observations and passed unanimously at its April meeting the following motion which it would like to present to the House of Delegates at its forthcoming meeting:

"That the House of Delegates request the President of the State Medical Society to direct an appropriate committee to make an in depth study of the activities of the State Medical Society with regard to utilization of physician time and effort and Society monies. This committee to report at the Society's next annual meeting making recommendations for revision or elimination where possible of these activities which do not constitute an efficient and/or worthwhile utilization of members time and effort and Society's monies."

The Durham-Orange Society is very anxious that its action not be construed as criticism of any officer or member of the State Medical Society or its executive offices, but rather as an effort to determine if there are any changes that might make for a more efficient and effective organization.

PRESIDENT PASCHAL: You have heard the reading of this communication. You will note that it came and was dated, I believe, April 18. This comes to us as a recommendation, as I understand it, to be passed on to the House of Delegates, in which it requests that the President designate this committee.

We have had, I might say, the Committee on Committees several years ago, which understood some action in this field. Earlier than that, we had some investigation by an in depth study done by one of the researchers in the field, Edlund group, and I think it's good periodically to take inventory of what we're doing and set goals. This might be appropriate.

What is the feeling of the Council concerning this recommendation that you received from Dr. Hughes for the Durham-Orange County Medical Society?

DR. RAPER: Move it be approved and sent to the House of Delegates.

(The motion was seconded by Dr. Murphy.)

DR. RAIFORD: Does this constitute a resolution, or can this be brought up as a spontaneous action?

PRESIDENT PASCHAL: I think this does not apply to the resolutions. It was not submitted as a resolution, and I think it can go from us to the House of Delegates as a recommendation of the Council for action.

DR. GLASSON: Mr. President, may I speak to two things which you brought up, and which had been done.

The Committee on Committees we felt was a good action and was well handled, but was limited in its scope. As to consideration by the consultants, outside consultants are more or less limited in saying whether you function efficiently in areas where you desire to function, and they cannot decide for you what you're going to do. They simply looked at what we were doing and decided whether we were doing these efficiently or not, and this also is a limited scope.

It is hoped that such a committee would provide some guidance from the State Society as to a self-evaluation.

PRESIDENT PASCHAL: Thank you, Dr. Glasson. Is there further discussion? If not, are you ready for the

question? All in favor let it be known by saying "aye"; opposed, like sign. Carried.

Now the next has to do with the membership status of Dr. Annie V. Scott.

MR. BARNES: A letter dated April 26, 1966, directed to Dr. George Paschal, President of the Medical Society, regarding Annie V. Scott, nomination for Honorary Membership.

I have checked with Jack Lynch in High Point regarding this lady and her request for continued membership since she did not join the State Society until 1954. However, about thirty years of her life were spent as a medical missionary in China, and upon return to this country she got her Board in Pediatrics and was on the faculty at the University of North Carolina. She has since retired at the age of 75 or 76 and is living in High Point. As I understand it she is somewhat crippled, but is considered a very nice person who has given her life to medicine in the mission field and at home until she was unable to do so any more. She is a native of Guilford County.

As Councilor for the 8th Medical District, I feel that she is eligible for Honorary Membership in accordance with Article IV, Section V of the Constitution. I would recommend, therefore, that the Council put her name in nomination for Honorary Membership and have it presented to the House of Delegates.

DR. KOOMEN: I know her, and she's a very impressive lady.

PRESIDENT PASCHAL: Dr. McNeill, do you have further comments about her in support of this recommendation?

DR. MCNEILL: It is the recommendation of Dr. Shaffner that she be given this.

PRESIDENT PASCHAL: What is your pleasure concerning the recommendation of our Councilor?

DR. BEDDINGFIELD: I move the Council nominate her for Honorary Membership.

(The motion was seconded by Dr. McCain.)

PRESIDENT PASCHAL: It has been moved and seconded. Is there further discussion?

If not, all in favor please say "aye"; opposed, like sign. The motion is carried without dissent.

We go to Item (f), Request of Robert E. Daniels, M.D., Buncombe County, for inactive membership status.

MR. BARNES: Dr. Robert E. Daniels, being on the rolls as an active member of the State Medical Society from Buncombe, was sent the invoice in December, February and March, for dues, and then the follow-up letter that was sent to all unpaid members on April 1st, as directed by this Council.

He has typed a response to the letter notice as follows:

Dear Mr. Barnes:

Inasmuch as I find my health is failing, and I am on limited practice, I would appreciate it if information could be provided relative to maintaining membership on an inactive status. I am now 62

years of age and I have had membership for about 35 years. Please advise.

Now we have no inactive status—dropping or certifying that one is disabled, and the Society does authorize the regular exemption of a disabled inactive member.

DR. WELTON: Does the Councilor of his district recommend it?

DR. RAPER: This is the first that the Councilor heard of it. It apparently didn't go through channels. It was one of the things through central billing, not through the County Society. I think this should be referred to the County Society, and I think the Council should accept the recommendation, if they see fit, of the component medical society.

PRESIDENT PASCHAL: You have heard the discussion of Dr. Raper. Is there a motion that we handle that in this fashion?

DR. DUCK: I think it's a very logical approach, and I make such a motion.

PRESIDENT PASCHAL: It has been moved that this be referred to the County Society and to the Councilor of the district for consideration and action with regard to this recommendation.

Is there a second?

(The motion was seconded by Dr. Murphy.)

PRESIDENT PASCHAL: Further discussion? If not, all in favor please say "aye"; opposed like sign. Carried.

We have a Gaston County resolution that came in three days ago.

I will ask Mr. Barnes to read it.

MR. BARNES: This is dated April 23rd and received by us April 26th and directed to me.

Dear Mr. Barnes:

Below you will find a resolution passed by the Gaston County Medical Society at its regular meeting, and that was on April 4th. It is forwarded to you with the express request that you give it to the Executive Committee of the Medical Society of the State of North Carolina, and that every effort be made to have this resolution presented to the coming State Society meeting in May, 1966, with the idea of approval of the entire Society.

GASTON COUNTY MEDICAL SOCIETY RESOLUTION

RESOLVED, that the members of the Gaston County Medical Society believe in rendering medical service free of charge to deserving individuals and will continue to do so when indicated.

However, since members of government agencies are paid reasonable salaries for services and since the hospitals are paid reasonable charges for inpatient care, it seems unreasonable to exclude physicians from receiving reasonable compensation for their services.

Although we believe in paying taxes, we strongly feel that medical expenses incurred by recipients of public help are a public responsibility and therefore, should be entirely provided from public funds. When a government forces physicians to accept token fees it is imposing a double taxation on this group.

Therefore, it is resolved that when a government

agency agrees to underwrite medical expenses for a segment of the population, it will be expected to pay reasonable fees for medical services.

Thanks very much, signed J. T. Miller, Secretary-Treasurer of the Gaston Medical Society.

PRESIDENT PASCHAL: As I understand this resolution, it would come under our provisions for submission of resolutions to the House of Delegates. It doesn't meet the requirements to be submitted at this time. However, since it incorporates ideas and attitudes which have been previously expressed that are going to be passed on, I think that we can consider this, and possibly take some action by the Council approving its intent.

But we would have the responsibility of pointing out to the Gaston County delegation that their resolution did not reach us in time for formal presentation among our resolutions.

MR. BARNES: They understand that. That's why they presented it to the Council.

PRESIDENT PASCHAL: The Council will have an opportunity to pass it on to the House of Delegates as a recommendation, if you so desire. What is your pleasure concerning this?

DR. GLASSON: Is it within statutory limitations to pass it on to the House of Delegates?

MR. BARNES: Council can do it.

DR. GLASSON: Move it be done.

(The motion was seconded by Dr. Murphy.)

(The motion was put to a vote and carried without dissent.)

PRESIDENT PASCHAL: Jim, do you have other things that pertain to this particular section?

MR. BARNES: No, that finishes that section.

PRESIDENT PASCHAL: If you will look to Resolution No. 12, going to Item 6, sub-item (b) which has to do with the North Carolina Medical Foundation, Inc., resolution of the Board of Directors, I will ask Mr. Barnes if he will read the Resolution No. 12 and then I'll ask Mr. Anderson to comment on it further.

MR. BARNES:

The Executive Council has authorized the incorporation of the North Carolina Medical Foundation, Inc., devoted exclusively to educational, scientific and charitable purposes which are exempt from taxation under the U. S. Internal Revenue Code.

The corporation has been organized, and its Charter and By-Laws have been submitted to the District Director of Internal Revenue for determining that it meets the requirements of the statutory exemption, particularly for the acceptance of contributions and bequests which are tax deductible. The membership of the Foundation will consist of the voting members of the Executive Council of the Society which will elect the directors of the Foundation, who will in turn elect its officers. It will be possible for the Foundation to construct a building, borrow money for such construction, and to lease part of it to the Society for use by its headquarters staff, and to use the other portions of the building for its educational and scientific purposes. The House of Delegates will be asked to approve the implementation of

the Foundation and to consider the advisability of transferring some property or funds of the Society to the Foundation for the construction of a building and for use in its activities.

PRESIDENT PASCHAL: I might say that the called meeting at the Velvet Cloak in Raleigh, on November 21st, was in part to consider this proposal.

I will ask Mr. Anderson if he will further elaborate on this proposed Medical Foundation.

MR. ANDERSON: The purpose of the Foundation—the purpose it would serve would be this: It would be able to receive donations and bequests which would be tax deductible, without any question, as predetermined by the Internal Revenue Service. The composition of the membership of the Foundation as explained to you at the last meeting would be the Council itself, the active members of the Council, who would elect a Board of Directors. The Board has been elected by resolution of the first incorporators, and those directors as named were George Paschal, President, Vice President Frank W. Jones, Vice President T. S. Raiford, Secretary Charles Styron, Treasurer James T. Barnes, Executive Director James T. Barnes, and By-Laws have been adopted.

So we are ready to submit to the IRS a request for determination of the tax exempt status.

Now I think that the Council and the House of Delegates might consider approving the implementation of the Foundation to serve in whatever capacity you wish it to serve. If you want to transfer the building lot to the Foundation, that should be considered; and if you want to authorize the Foundation to do anything regarding authorizing any committee of this Society to do anything regarding further plans for a building, that could be considered.

So there are two things you can consider: Authorizing the Foundation to be implemented, meaning to authorize the transfer of the building lot to the Foundation at such time as might be deemed advisable, and also to authorize some committee to go forward with some plan regarding the building headquarters, if you want to consider it.

PRESIDENT PASCHAL: You have heard this discussion by Mr. Anderson. Is there a motion that we follow Mr. Anderson's recommendation in these two areas?

DR. BRIDGER: I make a motion that we follow this. (The motion was seconded by Dr. Garrard.)

DR. GLASSON: I make a motion that we approve the implementation of the Foundation.

PRESIDENT PASCHAL: This is a substitute motion.

MR. ANDERSON: Make the motion specific to authorize the transfer of sufficient stocks to the Foundation to enable the Foundation to purchase the property.

DR. GLASSON: I include that in my substitute motion.

PRESIDENT PASCHAL: Is there a second?

(The previous seconder concurred.)

Is there further discussion about this? If not, are you ready for the question? All in favor let it be known by saying "aye"; opposed by like sign. The motion is duly carried without dissent.

DR. BEDDINGFIELD: There is still a motion on

the floor, and I guess another substitute motion would be in order.

I would make a motion that we continue a committee on Headquarters Facility to act in an advisory capacity to the Foundation.

(The motion was seconded by Dr. Rhodes.)

PRESIDENT PASCHAL: It's moved and seconded that we continue the Committee to act in an advisory capacity to the Foundation. Is there discussion? Are you ready for the question?

DR. GLASSON: In this respect it would seem in order for such a committee to make recommendations about making plans for the building in this type of thing, and would not be then necessary for us to pass any further motion about employing an architect, and so forth.

PRESIDENT PASCHAL: I would think that that function would be encompassed in the intent of this.

Are you ready for the question on this substitute motion. All in favor say "aye"; opposed by like sign. The motion is carried.

DR. BENTON: I'm a little bit disturbed about the substitute motion he made specifying that it come from bonds. It might not be that everybody is in agreement that we want to keep that property on the Durham Highway. The way you have passed it is just fine, because I would rather give them the bonds than the property—or whether it should be from the Durham-Raleigh property or common stocks.

I wonder if you wouldn't want to delete that.

PRESIDENT PASCHAL: We voted on Dr. Beddingfield's substitute motion.

DR. RAIFORD: Wouldn't it be better, if a change is considered, to say that such assets as deemed feasible by the Finance Committee and the Executive Council? That does not limit it to anything. In order that we do that, we would have to rescind motion number one and make another motion.

DR. JONES: I so move.

PRESIDENT PASCHAL: It has been moved that the first motion be rescinded.

(Several Council members seconded the motion.)

PRESIDENT PASCHAL: This would require a two-thirds vote to be effective. Are you ready for the question on this? All in favor of rescinding the vote let it be known by raising their right hand. It's carried without dissent, by unanimous vote.

DR. RAIFORD: That such assets be transferred to the Foundation as deemed expedient by the Finance Committee and the officers of the Association.

MR. ANDERSON: That would be sufficient.

DR. RAIFORD: Well then, to include this original resolution, the motion should be in two parts: first, that we recommend to the House of Delegates that this resolution be accepted, and that it be further recommended that the Society be authorized to turn over such assets as deemed necessary by the Finance Committee and the Executive Committee of the Society.

MR. ANDERSON: The Executive Committee of the Society.

PRESIDENT PASCHAL: I think that would accomplish the purpose.

(The motion was seconded by Dr. Welton.)

DR. BENTON: If the Finance Committee and Executive Committee are displeased on where the money is coming from who is going to be the say-so? Should it be left specifically to one or the other?

PRESIDENT PASCHAL: I think that the Executive Committee and the Executive Council would have the final word.

Is there further discussion?

(The question was called.)

The question has been called. All in favor let it be known by saying "aye"; opposed by like sign. The motion is carried without dissent.

I would like to express our thanks to the Headquarters Facility Committee for the time they devoted to this, and to Mr. Anderson and Mr. Barnes, and others, who participated in it. I think they have done a fine job, and I think we will have something to be proud of.

We shall go on to Item 6, sub-item (c), Committee on Professional Insurance.

MR. BARNES: This is simply reference to the action by mail vote of the Executive Council, a communication that went to the members of the Council on the 22nd of March in regard to the two group professional insurance programs; that is, the Major Medical and the Disability Expense Coverage programs that had had notice of the cancellation, and that there was a positive vote unanimously in favor of the Lumbermen Mutual Program that the Committee on Professional Insurance had worked out.

This is simply a follow-up letter that went to all the doctor members of the Society. We received a copy of it from Dr. Martin on April 28th, but I think it went out about the first of April:

Dear Doctor:

Medical Society of the State of North Carolina Major Hospital and Business Overhead Program Your Insurance Committee, after extensive study of many insurance proposals of various companies, decided to adopt these offered by the Lumbermen's Casualty Company. We are happy to announce that effective June 1, 1966, and thereafter, the members of the North Carolina State Medical Society will be offered coverage under the new contracts. These will be the only official major hospital and business overhead expense programs endorsed by your Association.

We hope that all of you will give these programs serious consideration, and that you will avail yourself of this excellent insurance coverage which is being offered at low premium rate made possible by the mass purchasing power of the members of the Society.

You will receive information concerning the two plans within the next few days. Those presently insured will receive their new policy.

James F. Martin, Chairman of the Committee on Professional Insurance.

This is simply a report on the Committee that they

have implemented this program that you voted to endorse.

PRESIDENT PASCHAL: Do I hear a motion that this be accepted as information?

(Such motion was made by Dr. Styron, seconded by Dr. Bridger.)

Any discussion? All in favor let it be known by saying "aye"; opposed, like sign. The motion is carried.

The Statement of Policy on Alcoholism by the Committee on Mental Health.

Would Dr. McCain like to speak to it?

DR. MCCAIN: Alcoholism is very social type illness, and we thought we ought to give it medical direction. This statement is patterned along the AMA statement on alcoholism, and the AHA statement on alcoholism, and it just sort of brings it to North Carolina.

Our Committee has been circulated, the preliminary draft on alcoholism, and then had an extensive distribution as indicated in the preliminary draft, and the revised statement, as indicated, and I would like to move its adoption.

(The motion was seconded by Dr. Raper.)

PRESIDENT PASCHAL: You have heard the motion and it has been seconded. Is there further discussion? If not, all in favor let it be known by saying "aye"; opposed by like sign. That's carried.

(The meeting recessed for luncheon at one o'clock.)

SATURDAY AFTERNOON SESSION

April 30, 1966

The meeting reconvened at two o'clock, Dr. George W. Paschal, Jr., President of the Society, presiding.

PRESIDENT PASCHAL: Let's come to order please, and we'll proceed.

Item 6, Sub-item (f), Committee on School Health, regarding expenditures of funds going to various state agencies and local schools for school health.

Our Committee on School Health has wanted for sometime to request the Governor to appoint an advisory Committee to the Department of Public Instruction which has to do with the various Federal programs, and also with the programs within the State of North Carolina.

Dr. Keleher has made overtures to them to have some meeting, and this was not convenient for them to accomplish. He requested that the State Board of Health and the Medical Society confer with Dr. Carroll at a convenient time, and with some little difficulty Dr. Koomen and I did finally arrange to have a conference with Dr. Carroll about these matters.

Dr. Carroll stated that he believed strongly that the people who were doing things ought to be doing them within the limits of their capacity, and he did not think that school officials ought to try to assume responsibilities that were more properly directed to the medical profession.

Our conference with Dr. Carroll was cordial, and we had the feeling that he would be cooperative in this.

As you know, there is a large amount of money coming to the State through some of the Federal pro-

grams, with particular reference, I think, to the Office of Economic Opportunity. That shakes down to the county level in which the local schools receive these funds by-passing the Department of Public Instruction, and it goes directly to the local school rather than passing through the established channels from Dr. Carroll's office down to local boards, or local school units.

In a number of areas, in a number of counties, these funds have been received, and locally they have gone to considerable length to try to disburse these funds and find ways of spending this money in areas in which they have no competence to make decisions without medical advice.

It is in this area that we are concerned, and it's because of this that we are hopeful that an advisory council will be established.

I'm certain that some of this has rubbed off on the local communities of some of our Council members. I would say that there will be a continuing effort to have such an advisory council established, and to develop some appropriate guidelines and working arrangements for the utilization of these funds as they become available.

I submit this to you for information in regard to this particular item on the agenda.

DR. MCCAIN: There are some schools that have funds for nurses, and these nurses carry out their duties without medical supervision.

PRESIDENT PASCHAL: In some areas.

DR. MCCAIN: Five or six areas over the state.

PRESIDENT PASCHAL: That's true.

Dr. Carroll's idea was that he would establish the medical director to supervise the operation of this program within the city school systems, and that under him he might have an assistant director; but if he did not have, he would possibly have fifteen nurses working under him in this area which would be under the supervision and direction of competent medical men.

The technicians, as they might be needed, or others necessary for the implementation of this program, would be brought in.

Dr. Carroll further pointed out that in a community such as High Point, or other areas in North Carolina, that if the people locally wanted to employ a nurse, that with these funds they could outbid any of the other hospitals or doctors' offices, or Public Health Service, for the services of this particular nurse.

They have these funds, and they're trying to find some way to dispense them.

I think Dr. Beddingfield has had some interesting experiences with some phases of this on a local level. Maybe he would like to speak to this.

DR. BEDDINGFIELD: I think there are two facets to this problem. First of all, there is the problem that has existed for a number of years and is beginning to come into sharper focus, and actually this is sort of an intrastate departmental rivalry regarding control of school health funds between the State Board of Health and the State Department of Public Instruction as to who is going to formulate the program, who is

going to have control over the funds that the legislature appropriates for a state health program.

I don't know if this issue has ever been adequately resolved. This is one part of it.

The second part is the new money that's coming in through the Office of Economic Opportunity, and also through the Title I of the Education Act of 1965.

As far as personal experience in Wilson County, we have two schools that have \$835,000 to spend between now and the first of August, and they're trying hard to spend it.

I found, for example, I was called upon to do physical examinations on ninth graders in one school. I got out there and I found out that the Health Director had already been out and he had taken all of the obese children, mainly females, and had arranged for referral to internal medicine people with instructions and authorization for complete endocrinological studies. I believe all of us agree that if you have obese ninth graders, that it's more often due to too many Pepsi-Colas and moon pies than to endocrine defects.

Yet this authorized a rather sophisticated survey, 24-hour urine, and so forth. I think this is another example of how tax money is being spent foolishly.

PRESIDENT PASCHAL: I think so. I'm aware of the two different areas which you mention. I avoided speaking of the first interagency rivalry, so to speak, or conflict, because I was waiting for possibly Jake to come back and let him speak to it himself.

But since he's not here, I think I can tell you this, and I believe this reflects his attitude.

This problem was raised at this meeting with Dr. Carroll, and Dr. Koomen proposed that they get into a conference with these people and iron out these differences and find out wherein the differences lay, and to make some effort at their resolution.

MR. BARNES: There are two points that I might add, if I may be permitted. About three or four weeks ago, Dr. Joe Knox, who practices pediatrics in Wilmington, called me by telephone and said that he had been engaged by this Elementary Education Act program to do some medical advisory work in that program, in New Hanover County, and that this involved a considerable amount of eye work, and that the ophthalmologists in Wilmington had rather declined to cooperate, based on the compensation that the local school people were offering for these services.

He was very much concerned because he thought it might develop that this would drive the local school people into engaging optometrists to do this eye work which ostensibly should be done by qualified ophthalmologists in Wilmington and eye men.

He wanted that related to the Medical Society for consideration at the annual session. I have brought it to the attention of Dr. Holt, Chairman of the Committee on Eye Care, and he was going to ferret out from the local ophthalmologists what the story was, and then talk to Dr. Knox about it. He thought maybe he would bring a report here this week.

The only other incident I have had is in this one community of Winston-Salem, he said that he had allocated something close to \$900 for Forsyth County

for this elementary education activity, and that they were paying usually the customary charge of the physician, and raising no question about it whatever.

It was strange that one county had one slant and another a different slant with the same money.

DR. BEDDINGFIELD: I have sort of indicted our County Director, but in defense I might say this: He also brought it to the County Medical Society for the approval of the program before he started.

As far as office calls and laboratory procedures and so forth, he did agree to a schedule of the usual customary fee and things. He has tried to secure cooperation.

MR. BARNES: One other item, Dr. Paschal. On the 21st of April, Mr. Charles Spencer who is in charge of the School Health Program in the Department of Public Instruction, called me and said that he had conceived the idea that the old arrangement with the Medical Society for 60 per cent of the high level Blue Shield schedule was not adequate compensation for what the doctors in North Carolina were doing in the school detection program.

He thought that he was going to Dr. Carroll with a recommendation there be some negotiation on this at the present time. He called me back the next day and wanted to set up a meeting for the 25th of April, and there were some conflicts that I pointed out to him on that, and he called me back the same day and said that they had conflicts too, and wanted to set up a meeting on the third day of May.

I said "Well, we'll be in Asheville the third day of May." The next day his secretary called and said they had called the whole thing off, because they couldn't find a propitious time to meet.

PRESIDENT PASCHAL: It's recognized there are inequities in the operation of this program in some of the areas of providing school help.

DR. BEDDINGFIELD: I think this is so complicated and there are so many ramifications—for example, there is relationship as to what's going to happen under Title XIX; I think the Council cannot conceivably take any action today, and I think it simply ought to be received as information.

PRESIDENT PASCHAL: I think that this would be only information, but I thought it was something you ought to be apprised of, and be aware of what's going on, and we'll try to keep our Committee on Child Health particularly advised, and we will offer them our support.

We'll move on to Item (g), Medical Society of the State of North Carolina membership on North Carolina Health Council.

MR. BARNES: This is on the agenda primarily because it's on the agenda of the Auxiliary.

The Medical Society, as you know, became a member of the North Carolina Health Council by authority of this Executive Council in 1948, and has consistently had representation as one of the member agencies of the Council; so did the Auxiliary many years later become a member.

There is some question in the Auxiliary as to wheth-

er this is a proper membership undertaking for the Auxiliary.

Dr. McMillan wrote me sometime ago, as Chairman of the Committee Advisory to the Auxiliary, about our status, because it's going to be questioned in the Auxiliary. I thought if there was any point to it that you all might consider whether or not you've got a changed view about membership on the Health Council.

DR. BEDDINGFIELD: Mr. President, as a past president of this organization, he ought to be the one to discuss it and make recommendations about it.

PRESIDENT PASCHAL: Mr. Barnes, do you have a recommendation?

Before you remark, I might say that Mr. Herndon, I believe, is the current President of the Health Council, and I was talking with him a few days ago, and he's come up with the idea of establishing an advisory group composed of laymen, informed laymen, and some doctors, about plans for expansion of that program, and we might hear more about that as time goes on. But will you speak to this?

MR. BARNES: Since I have been requested to speak to it, I might say this: In 1947, when the first proposition was made that the State Medical Society encourage the organization of the North Carolina Health Council, I was very much opposed to it personally, and the then officers of the State Medical Society didn't see any particular reason for it.

But the next year, when the movement moved on to the organization of the Health Council, this Council decided it would be better to be a part of it and know what went on, and guide it, and direct it as much as it possibly could; and therefore it voted that the Medical Society should be a member of it, and the President and the Executive Secretary would be representatives to the Health Council.

Well, I functioned in that capacity along with the intercurrent President for a number of years, and then got tagged as President in 1959 or '61, something like that, and aside from this program of endeavoring to set up a health service for state employees, I never saw anything that they did that was incompatible with the State Medical Society, and so forth.

That particular subject is still on the agenda of the Health Council, and I think that the Health Council probably will bring it to some sort of fruition one of these days, if we can ever get the Governor and the legislature to give them some money; but the Medical Society ought to be in there guiding it, and therefore I think that your membership is very pertinent.

PRESIDENT PASCHAL: Are you asking us to make any decision or recommendation?

MR. BARNES: Not unless you decide to come out of the thing.

PRESIDENT PASCHAL: Participation in the Auxiliary.

MR. BARNES: They have the information that we are participating, so I guess it's not up to us to tell them what to do.

PRESIDENT PASCHAL: This requires no action.

We have taken care of Item (h).

We will move to Item (i) letter from Dr. Robert W. Williams, regarding annual dues, State, and AMA.

MR. BARNES: This is simply a letter to me in response to his dues invoice. It's from Dr. Robert W. Williams of Wilmington.

Dear Mr. Barnes:

The State Dues have been raised each year for the past three years, (which is not quite correct) and now I understand the AMA dues will be raised next year (and there is some understanding that they are seeking that). I also note the addition of the political contribution on the billhead. Please see that when the delegates meet, my complaint is raised. These societies are not helping me in any measure comparable to the American College of Surgeons or other specialty groups.

(signed) Robert W. Williams

PRESIDENT PASCHAL: Do you want any action on that?

MR. BARNES: I think it will be an issue in the House of Delegates because of some resolutions.

MRS. KING: There are some dues billing resolutions.

DR. RAPER: I move it be received as information, and this subject is covered by another resolution.

(The motion was seconded by Dr. Beddingfield.)

PRESIDENT PASCHAL: It is moved and seconded that this be accepted as information. Discussion? If not, all in favor say "aye"; opposed, like sign. The motion is carried.

The next item (j) Hospital Saving Association, Board of Trustees vacancy created by death of Louis L. Klostermyer, M.D.

MR. BARNES: It's an unexpired tenure extending to 1968.

PRESIDENT PASCHAL: No, I don't think so.

DR. McCAIN: Received as information.

PRESIDENT PASCHAL: With regard to this, I think it is appropriate at this time to bring to your attention a communication that we received this morning. Jim has not as yet seen it. It was directed to me, and it concerns Dr. Klostermyer. I think it would be appropriate for this information to be transferred to you, and I will ask Jim to read the letter of transmittal and the resolution proposed by the Hospital Saving Association.

MR. BARNES: This is a letter dated April 27, 1966, directed to Dr. Paschal, President of the Society.

Dear Dr. Paschal:

During the quarterly meeting of the full Board of Trustees of the Hospital Saving Association of North Carolina, Inc., on April 27th, the attached resolution was unanimously adopted:

The entire Board is greatly indebted to Dr. Klostermyer, who served so faithfully as your appointed trustee, and who so intelligently helped guide the association all the time he was a member. His quiet and dignified manner, and his wisdom and fairness in all matters were always apparent. The rest of the Board and all of the staff members with whom he worked so cooperatively will greatly miss him.

Sincerely, E. B. Crawford, President

The resolution in memory of Louis L. Klostermyer:

Whereas Dr. Klostermyer was duly elected as a member of the Board of Trustees of the Hospital Saving Association in July 1960, and

Whereas Dr. Klostermyer faithfully attended every meeting of the Board of Trustees except when prevented from doing so by illness, and he brought to the Association his long interest in the prepayment field beginning in 1939, when he was a charter member of the Western New York Blue Shield Plan, and above all he brought to the Association his good judgment, integrity and unfailing understanding, all of which have contributed immeasurably to the betterment of this Association and its service to the physicians, the hospitals and the people in North Carolina, and

Whereas it was with a deep sense of loss that the members of this Board learned of his passing on March 10, 1966, after a short illness, and wish to express our appreciation for his service and sympathy to his family, therefore be it

RESOLVED. That the Board of Trustees of Hospital Saving Association does hereby acknowledge its sincere appreciation for the services of Dr. Louis L. Klostermyer, and does express to his family its deep regret at his death and its devotion to his memory as both a friend and counsellor; be it further

RESOLVED. That this resolution be spread upon the minutes of the Board and that a copy of this resolution be transmitted to the members of the family of Dr. Louis L. Klostermyer and to the Medical Society, Hospital Saving Association of North Carolina, Inc.

J. C. Eagles, Chairman, Board of Trustees.

PRESIDENT PASCHAL: This is appropriately entered into the minutes of this meeting.

PRESIDENT PASCHAL: Is there a proposal? Is there a proposal for replacement of Dr. Klostermyer?

DR. MURPHY: I would like to nominate Dr. F. A. Blount of Winston-Salem. Dr. Blount is a pediatrician. The pediatricians have not been represented I think in our Blue Cross, which is basically a hospital and surgical plan. This is one branch of medicine that hasn't had representation, and if we're having plans backed by the doctors, I think it ought to represent all the doctors.

Dr. Blount is in private practice there, head of the Visiting Committee at Chapel Hill. He is on the visiting staff at Bowman Gray. He is well qualified, an excellent man from a professional standpoint.

(The motion was seconded by Dr. McNeill and Dr. Williams.)

PRESIDENT PASCHAL: I am going to suggest that Dr. Murphy be asked to place this name in nomination tomorrow at the appropriate time.

And if there is no objection, we will ask him to also indicate that this is the recommendation of the Council.

DR. DUCK: I make a motion that nominations cease and he be recommended.

(The motion was seconded by Dr. Williams.)

PRESIDENT PASCHAL: Further discussion? If not,

all in favor say "aye"; opposed by like sign. The motion is carried.

Now we go to item (k), vacancy on the North Carolina Board of Nursing created by the death of Dr. Robert N. Creadick of Durham.

We have made recommendations to the Governor for consideration of the appointment of Dr. E. R. Caldwell to replace Dr. Creadick on the Board. A letter of recommendation was sent to the Governor. It was duly acknowledged, and no action so far as I know has been taken on this appointment at this time.

I am optimistic that this might be done. I bring this to you for information.

Now the next item we will go to is (1), Training Task Force Project—North Carolina State Board of Health (Medical Society share in plans and information in development of the expansion of this project in developing plans for the implementation of some of this new legislation.)

Dr. Burns Jones is concerned with this. Dr. Koomen is also concerned with it, and one of the men his department—I believe Dr. Donnelly—requested that we have our task force group get together and work on plans for providing and promoting a written plan for the implementation of certain phases of Public Law 89-97.

Now Dr. Jones has asked for an indication of the attitude of the Society in working and planning in this area. He is not asking for an expression of opinion concerning the program itself, but he is hopeful that the Medical Society would participate in the planning and study of this as it develops.

I did write to Dr. Jones and tell him that the Medical Society was interested in the problem, and that we were interested in studying it further and knowing more about it, and working with them in the future development of plans for implementation.

Dr. Jones is asking for the cooperation of the Medical Society in an expression of the willingness of the Medical Society to participate with the training task force project of North Carolina State Board of Health in developing plans, further plans for the implementation of Public Law 89-97.

DR. BEDDINGFIELD: Are there three task force groups?

DR. KOOMEN: Yes. Perhaps the choice of names, in view of the other, is not a very good one.

PRESIDENT PASCHAL: I thought as the study was carried on, this was something that the Medical Society could not afford not to be informed about, and not to have some plan or some part in.

If there are serious problems that develops and they can be brought back to the Council for their consideration, that would be fine. But nothing has been done about this. No meeting has been held for it. But I simply indicated that the Medical Society did have a willingness of participating when the matter was considered.

DR. McCAIN: What is the area of concern of this task force designated here?

MR. BARNES: Training.

DR. McCAIN: Of whom? Of physicians, technicians?

PRESIDENT PASCHAL: Not so much physicians, but

allied personnel, and all of the people that might be involved in this thing.

DR. BEDDINGFIELD: Home health aids.

DR. MCCAIN: A program for the state.

PRESIDENT PASCHAL: This would be a statewide thing.

But in the training of allied health personnel, nurses, technicians, aids, physical therapists, off of these people, they wanted to have the guidance of the Medical Society and informed medical people in the development of this training program.

Dr. Donnelly asked the Medical Society's task group meet with him to study and consider developing guidelines or model plan for the implementation of this legislation in North Carolina.

The Governor's office, as I understand it, has requested that a plan be submitted in writing; whether this means that he is considering the Board of Public Welfare to do this, I don't know. But they have asked them to submit a plan in writing; and before that was done, he wanted to meet with our task force for consideration of this problem and see if we couldn't develop guidelines along which we could proceed.

Now with that in mind, we did have a meeting on Tuesday night. The original model plan, I believe, had been withdrawn. Sometime earlier we got this information. So actually we did not get much accomplished.

Dr. Koomen was there. Possibly he would like to remark about this at this time.

DR. KOOMEN: In confirmation of what you say, we had been asked by Mr. Rankin following the visit that Dr. Paschal and I made to him to discuss the relationship or hope for a relationship between the State Board of Health, Medical Society, and the Department of Administration in the Governor's office.

He asked that we device a plan and submit it to him. As we were getting under way with this, we discovered that the model plan which had been put forth for the guidance of the State had been withdrawn, and that a new one is to be fashioned, the precise date of which is not quite certain.

It also turns out that writing a plan for implementation of Title XIX, the expanded Kerr-Mills portion if you will, and the five types of welfare programs that must be incorporated into this over a ten-year period, is a much more complicated task than writing a similar plan for Title XVIII, or the so-called Medicare portion which has to do with those 65 and above, and those 65 and above who elect to take part about the physical payment portion.

We have been busy gathering data, writing and reviewing medical plans only to discover that the model plan had been withdrawn by the Department of Health, Education and Welfare, and that therefore we await it.

At any rate, the meeting to help get on with writing the plan could not go further at the moment because we did not have a model plan before us.

PRESIDENT PASCHAL: Thank you, Dr. Beddingfield, do you want to remark about this?

DR. BEDDINGFIELD: Very briefly, just to say

this: I don't know anything else that the Medical Society task force group, or the people at the State Board of Health, could do at this moment. I think this is consistent with a special meeting of the Executive Council in August of last year, at which we declared that it was the wish of the Medical Society that Title XIX being primarily a health care program be under the jurisdiction of the State Board of Health, and not the State Board of Public Welfare. Of course, this is compatible with the law.

The law requires only that Welfare determine eligibility; but as far as the development of the scope of services and the extent of services, and program evaluation of health services, this can very properly, and this Society thought it should be left within the Health Department of North Carolina.

One additional bit of information, since we met last Tuesday night. I have learned that various sections of the new guidelines have been drawn. They have not been published, but they are going to wait until all the sections of it are compiled into a handbook and publish it.

I have reason to believe that we might be able to get various sections of the plan as they are in draft form, so that we can go ahead and begin mimeograph work, and we'll pass this information along to Dr. Koomen as it is received. We might get some of it before he does, and he might get some before we do. But I think we should proceed on our stated policy that we would like to see this vast health program within the State Board of Health.

PRESIDENT PASCHAL: I think we will pursue that without further direction from the Council.

Dr. Kernodle?

DR. KERNODLE: I don't have anything further to add to it. I was not able to be at the Tuesday meeting, but I do think that we ought to pursue every effort to keep this within the State Board of Health.

PRESIDENT PASCHAL: It is my understanding, that there is no serious consideration being given to put this in the hands of the State Board of Public Welfare.

DR. KOOMEN: No information has been brought to us directly. We have been in communication too with the regional office of the Public Health Service, who have a group interested in implementation of both Titles XVIII and XIX, and they will furnish us whatever material they can out of plans so far approved in other states.

But we believe that things must be standing still pretty much in other states awaiting the guidelines. By standing still, I mean simply that while writing will be going on, ultimately this will have to conform to standards set up.

DR. BEDDINGFIELD: I think you ought to say this: While we don't know of any serious disposition on the part of the Governor to put this in the Department of Public Welfare, that the State Board of Public Welfare is just automatically assuming that they're going to have it, and they're proceeding to go ahead and write a program, and this ought to be known to this Council.

MR. ANDERSON: It's already got most of it.

DR. KERNODLE: That's the reason I said we should pursue very diligently to keep this, or get this in the State Board of Health. And as I mentioned to Jake just now, California has a plan. It may not be a good model plan, but they have something going, and there are other states that also have something going, and I don't think we should sit back and wait for all the information without going in and making a plan, because if we do, we're going to be on the outside looking in, and the Welfare Department will have it.

PRESIDENT PASCHAL: I believe that our task group is available to work with the State Board of Health in developing this proposal and submitting it.

We bring these things to you for your information. I don't believe they require any action of the Council.

Now we go to item (m) Committee on Pharmacy and Councilor—2nd District—report on James Robert Howerton, formerly of Columbia (Tyrrell County).

DR. WILLIAMS: Mr. President and Gentlemen: I think it could be brief. Most of you remember my calling the attention of the Council at the last meeting about Dr. Howerton receiving a kickback from the drug store down at Columbia, which is my district, and you remember we had the court testimony, and that sort of thing.

Now this action briefly was that we would write Dr. Dees that the Council would not give consent for him to turn over his report to the Executive Secretary of the North Carolina Pharmaceutical Association at this time, as well as the second part of the action that we go back to the county society and see what they will do.

Well, I went down to his local society and carried all the information to them, and interviewed the people there, and turned it over to them and the report I received back if you would like for me to read it, I will—it's rather brief.

This is from David T. Tayloe, Chairman of a committee at Washington, North Carolina. You see, this Medical Society down there calls themselves the Pamlico-Albemarle Society, which is composed of five county societies, none of which have that county name. But it's a five-county society, and they call themselves Pamlico-Albemarle.

"After going over the letters and court testimony concerning Dr. Howerton's pharmacy affair, a committee was arranged to discuss the matter. Dr. Clark Rodman, Dr. Robert Sandy, both of whom are Past President of our local society, and myself were the committee. We made the following report:

Until you brought this matter up, we weren't aware that Dr. Howerton was a member of our Society. However, we contacted the secretary-treasurer, and indeed he has paid his dues for 1966. On reviewing our By-Laws, he cannot qualify as a member of our Society, since our By-Laws state that he must reside and practice in one of our five counties. Our secretary-treasurer did not realize that he couldn't continue his membership. His dues have been returned.

As you know, Dr. Howerton is now living in Norfolk, Virginia, where he is pursuing a resident train-

ing course. On looking over the court testimony, it seems quite clear that Dr. Howerton terminated his relationship with Mrs. Cahoon's Pharmacy himself voluntarily sometime ago. Since the question involving an alleged unethical practice was corrected, and since the physician no longer resides in our area, we see little to be gained by asking Dr. Howerton to come here to investigate this matter further.

Sincerely yours, David T. Tayloe.

I have talked to Dr. Tayloe about this subsequently, and they just feel like it's a closed matter; he's not under our jurisdiction; why should we get excited? That suits me all right, but it does leave one little gap here that I think we should think about and possibly act about.

We haven't answered the implications that might come of this, and the publicity surrounding it. I know Dr. Beddingfield wrote me about a copy of a letter that he expressed some opinions on about the Hart thing. It also hasn't satisfied my local newspaper editor who publicized this in the local paper when it happened.

MR. BARNES: There is one other item, Dr. Williams. I take it from this letter that the component society, county society, has refunded his 1966 dues.

DR. WILLIAMS: That's what they say.

MR. BARNES: They did that after the time that he not only remitted county dues, but state and AMA dues, which have been processed, and those memberships stand for 1966.

DR. WILLIAMS: They were remiss or wrong in accepting his dues when he couldn't legally be a member, according to their By-Laws, what they say here. He has to reside and practice.

MR. BARNES: We had no notice of that. He was on their rolls December 1st, and we billed him regularly for dues.

DR. BEDDINGFIELD: He is therefore still a member in good standing of the State Medical Society.

MR. BARNES: And of the AMA.

PRESIDENT PASCHAL: This is a prerogative of the local county society.

DR. WILLIAMS: They see little reason to pursue it further, according to this, according to their statements to me.

PRESIDENT PASCHAL: Would it be appropriate for our Committee on Mediation to communicate with him?

DR. WILLIAMS: I think the appropriate persons, whoever they may be—I'm not sure—it seems to me that maybe we shouldn't let this go unnoticed, and that we should let other interested agencies know that we do speak out and condemn so-called unethical practices such as this.

DR. BRIDGER: I make a motion Lynwood Williams look after the whole affair.

PRESIDENT PASCHAL: It is moved that Dr. Williams look after this affair. It is seconded?

DR. BRIDGER: I will put Jim Barnes in my motion with Lynwood to write him a letter.

DR. WILLIAMS: I think if it came from somebody with central based authority, it would be better than somebody locally, an individual.

DR. MURPHY: How about the Committee on Meditation?

PRESIDENT PASCHAL: You could say "acting on instruction of the Executive Council," you're communicating—

DR. WILLIAMS: I would like some privilege to put it on the level, rather than myself as an individual.

DR. BRIDGER: I will put Jim and Lynwood. . . .

PRESIDENT PASCHAL: There's a motion on the floor.

DR. WILLIAMS: Could we send any copies of such letter to Dr. Dees, or to any other people, or maybe the editor of the newspaper, or anybody interested?

PRESIDENT PASCHAL: I think it would be appropriate to send it to Dr. Dees. I hesitate to get involved with the newspaper.

DR. WILLIAMS: The thing of it is that at least Dr. Dees ought to be satisfied, because the pharmacists are howling at him about this type thing. And here is a case unanswered, and they can say to him "What have you done about this thing?"

PRESIDENT PASCHAL: You have heard the motion; is there any further discussion?

(The motion was seconded.)

PRESIDENT PASCHAL: There's only one objection that I have about this, in taking unilateral action, and that is that we haven't given the man an opportunity to be heard.

DR. McCAIN: He's still interested in North Carolina. He pays dues and is probably interested in coming back down here.

PRESIDENT PASCHAL: If the Chair might make a suggestion that we defer taking the action that would be representative in this motion, communicate with the doctor involved, give him an opportunity to be heard by our appropriate committee or Council, that he come here, or let him come before the Executive Committee of the Council, and then we'll be in a position to take whatever action we might feel is necessary.

DR. BRIDGER: I withdraw that motion and let it go that way.

PRESIDENT PASCHAL: If that meets with your approval, we'll follow that procedure.

We will now go to item (n) which has to do with the Insurance Industry Liaison Committee, which was done this morning.

DR. JONES: Since it's going to be dropped in somebody else's lap, would it be reasonable to ask the Council of the AMA for any help on this situation?

PRESIDENT PASCHAL: It might prove helpful. There's no reason why one could not communicate with the AMA for guidance and advice. I think you are at liberty to do that.

Item 7, Councilors, Annual report of the Councilors. First District, Dr. Romm.

DR. ROMM: No further report.

PRESIDENT PASCHAL: The Second District, Dr. Williams.

DR. WILLIAMS: You have just heard any addition to my report, which wouldn't be included.

PRESIDENT PASCHAL: Thank you.

The Third District, Dr. Bridger.

DR. BRIDGER: No further report.

PRESIDENT PASCHAL: Fourth District, Dr. Beddingfield.

DR. BEDDINFIELD: Nothing further.

PRESIDENT PASCHAL: Fifth District, Dr. Summerlin.

DR. SUMMERLIN: No additional report.

PRESIDENT PASCHAL: Sixth District, Dr. Glasson.

DR. GLASSON: Nothing additional.

PRESIDENT PASCHAL: Seventh District, Dr. Welton.

DR. WELTON: Mr. President, I would like to bring up a matter that Mr. Barnes and I encountered in a visit to the Gaston County Society a few weeks ago.

I am sure others of you have encountered it, and that is the confusion and apprehension that exists among many of our members about whether they're going to have to "participate" or not participate in Medicare.

What I'm thinking of is a recommendation or explanation, or both, from this group to the membership explaining the advantages of just continuing to bill the patients directly as they have done.

PRESIDENT PASCHAL: I'll ask you to express the last half of that sentence—I didn't quite get it.

DR. WELTON: An explanation and recommendation to our members of the advantages of continuing to bill the patients directly—I'm referring to people over 65—for services rendered in their offices, rather than taking assignments or other mechanisms.

PRESIDENT PASCHAL: May I ask what mechanism you propose for distributing this information?

DR. WELTON: Well, I don't have a concrete proposal at the moment. I would like to get the group's feeling about the advisability. I think there is a need for this, because I think apprehension flourishes on lack of information, despite the material disseminated. Many of the men haven't read it, and if they have, they haven't digested it. They can use any of our printed mechanisms.

DR. RAPER: Mr. President, I suggest that we, as an organization, say to the delegates or the members that they can do as they please; that we cannot, as an organization, request that they do not participate. Otherwise we'll be subject to an antitrust suit.

DR. WELTON: That's my whole point, if you will excuse me. You don't have to say to anybody whether you're going to participate or what. That's what the membership does not understand. You do not have to declare yourself one way or the other.

PRESIDENT PASCHAL: Dr. Kernodle?

DR. KERNODLE: This thing comes under critical point and the lawyer comes over here and tells me you can't get an antitrust program, but you can express and educate people by giving them both sides of the fence, and that's what the point is.

If they don't know, how in the world can they decide what they're going to do, whether fall into the line of accepted assignment, or bill direct? That's the only thing that the medical profession is honor bound to tell our members, what the heck the problems are,

and what are the advantages and disadvantages.

DR. KOONCE: The best way to do that would be through one of the new president's letters in the Medical Journal.

PRESIDENT PASCHAL: Yes, that might be an effective means of doing it.

I would say that we're having conferences and meetings that have to do with our new responsibilities, and we're making an effort to disseminate information and knowledge about these problems.

On this particular thing, do you think a President's page letter, or maybe an editorial would be sufficient?

DR. WELTON: No sir, I do not. With all due respect to the President's letter, I think we ought to use every means of communication we've got, plus some we haven't got. I know regional meetings are being planned, and investigations being made on telephone conferences, and so on.

On this particular point, a letter perhaps would be in order. I think it's going to take repetition to get this message across to our membership.

PRESIDENT PASCHAL: Do you have a motion regarding this?

DR. WELTON: I would move that we take definite action to inform our membership on both sides of the question, as Dr. Kernodle put it, on how to handle billing of patients under Part B of Medicare.

PRESIDENT PASCHAL: You've heard the motion; is there a second?

(The motion was seconded by Dr. Williams.)

PRESIDENT PASCHAL: Now is there discussion?

DR. JONES: Mr. President, it's rather clearly set forth in the law that you may elect to take an assignment or not to take an assignment. You may take three people that come to your office, and you may reject the next three for assignments. There's no question about that.

As I understand Dr. Welton, all he wants to do is to inform—and forgive me—the uninformed sector of our group, that there is an opportunity to continue to treat their patients just as they always have, bill them without taking an assignment; and there is no contravening of the law under those circumstances.

Is that in essence what you want to get over?

DR. WELTON: Very well put.

DR. JONES: A simple statement would be just about that long, and no penalty involved. But don't tell them they've got to do that, because sometimes they're going to want to take that assignment, if somebody doesn't have any money.

PRESIDENT PASCHAL: Is there further discussion? If not, are you ready for the question? All in favor let it be known by saying "aye"; opposed by like sign. The motion is carried.

Now we go to the Eighth District, Dr. McNeill representing Dr. Shaffner.

DR. McNEILL: Nothing further.

PRESIDENT PASCHAL: Tenth District, Dr. Raper

DR. RAPER: Nothing further.

PRESIDENT PASCHAL: Excuse me, Ninth District, Dr. Murphy.

DR. MURPHY: Nothing further.

PRESIDENT PASCHAL: All right, we have dispensed with item (a) under 8.

The Advisory and Study Commission, Dr. Howard Wilson.

DR. WILSON: No further report.

PRESIDENT PASCHAL: Annual Convention Commission, Dr. Paul Maness. He's not here. Is there anything further? I think we have that in the Compilation.

DR. BEDDINGFIELD: How about the '68 dates?

MR. BARNES: I might report on that.

The 1967 date has been confirmed. The only available date that doesn't conflict with some other group that would make it inoperable to us from the standpoint of check-in and access to the facilities would be the 20th to the 24th of May, 1967.

I do have a telegram here from the hotel people. It reads as follows: "Rate for the May 20 to 24, 1967, will probably be \$36 double and \$20 single, plus 10 per cent gratuity due to the proposed Federal minimum wages." This is signed by Convention Bureau Manager.

He talked to me one day last week and said that the Board had one or two meetings on it, and that they would notify their contractees that this was almost an inevitable problem if the Federal minimum wage act went into effect. They would have to pass that on to the various occupants of their room facilities.

While I'm on my feet, I also have a telegram from Mr. Richard Arey, General Manager, and Mrs. Mildred Callahan, Director of Sales, of the Jack Tar Hotel in Durham. It says:

Dear Mr. Barnes:

Best wishes for a most successful meeting at Asheville. We look forward to the opportunity of being your host in 1968. May we?" Sincerely.

That's really a matter for the Committee on Arrangements and has been committed to them. We're holding dates in Pinehurst for the 11th to the 15th of May in 1968, if that committee decides in September that's what they want to do.

PRESIDENT PASCHAL: All right; you have this additional information.

We'll pass on to (d), Professional Service Commission, Dr. Lindsey.

DR. MARK M. LINDSEY: I don't have any additional report, Mr. President. The Committee on Nurses asked me to call the attention to highlight the speech of Dr. Hale Wednesday morning at 9:30, and call your particular attention to this because of the pertinence of the nursing situation in North Carolina.

PRESIDENT PASCHAL: Public Relations Commission, Dr. Welton.

DR. WELTON: Nothing additional.

PRESIDENT PASCHAL: Public Service Commission, Dr. Thurston.

DR. THURSTON: No additional report.

PRESIDENT PASCHAL: Is there a motion that we approve the report of the Councilors and the Commissioners?

(Such a motion was made by Dr. Duck and seconded by Dr. Garrard. The motion was put to a vote and carried.)

PRESIDENT PASCHAL: Now the Annual Report of Committees.

MR. BARNES: These reports went out in the Compilation about ten days ago to the members of the Council. I don't know how many have read them, or whether you want to challenge them or direct an amendment of them, or question the principles involved in the reports, or what.

You have had them, and they're accessible. I would particularly call your attention to the Audit Report which is in the Compilation, and say that last year's operation did show a net profit of \$29,82.78 in the operation of the Society.

Except for the fact that we have withdrawn from this some of the contested IRS payments, and the contested State Employment Commission payments, which have amounted to about \$22,000, this would be a good picture.

I would also like to say that as of March 31st, of the budgetary estimates, revenue of \$280,000, we have received and deposited in the Societys accounts \$245,075.18. We only have a difference to go for the rest of this year of \$34,941.82 to attain that goal.

In that respect, we have something like 7,500 in advertising accounts payable to us, and we have probably a thousand dollars of local advertising accounts payable to us, and well have in addition all of the revenue derived from the Journal, both local and national, for the months of May through December.

So I'm not worried at all about attaining the \$34,941. that is the difference at the present time.

In the expenditure budget, as of March 31st, of the \$265,083 authorized to be expended, \$67,685.05 has been spent, and the difference is \$19,397.95 authorized to be expended that is still available.

Of course, the annual session is an expensive thing and it's going on now, but I think that the report here on March 31st of excess income over expenditures of \$177,309.13 is a good fiscal picture, and I'm very proud of it personally.

On the Journal, per se, someone has asked this question, and I would like for it to get into the record, that so far this year, with the accounts accruable and uncollected, we have a figure of \$19,971, and we have spent \$15,789.

Now I'm sure that at that time we owed for the March issue of the Journal, and I think that's a good picture of the Journal, because the revenue was up to \$3,900 for the month of April, and we think the Journal is showing progress.

DR. BEDDINGFIELD: What is the circulation?

MR. BARNES: About 4,250, I believe.

PRESIDENT PASCHAL: Thank you, Mr. Barnes.

Are there any other additions, or comments, discussion about any of the committee reports?

MR. BARNES: We have a Medicine and Religion Report which came to us this morning. Should I read this?

Dated April 27th, directed to Dr. John L. McCain, Chairman of the Committee on Mental Health.

Dear John:

I am asking you to help me out of a difficult

situation which is due entirely to my own procrastination. Will you as chairman of the Medical Society's Committee on Mental Health and Medicine and Religion bring up the following as new business at the Executive Council meeting?

(1) Request the Executive Council's endorsement of the Symposium on Medicine and Religion, THE PHYSICIAN, THE CLERGY, AND THE WHOLE MAN, to be held at Chapel Hill April 16, 17 and 18, 1967.

(2) Request approval of the Executive Council for the Medicine and Religion Committee to Co-Sponsor the Symposium with the UNC School of Medicine.

(3) Secure authorization from the Executive Council for the Medicine and Religion Committee to solicit financial support for the Symposium from philanthropic foundations and pharmaceutical firms.

I know this is putting you on the spot and I know that the agenda is already overcrowded. If this does not meet with Mr. Barnes and your approval, we will wait until the September meeting of the Executive Council.

DR. MCCAIN: They have done a good job about our getting a program format under way. We have worked closely with Fred Reid of Chapel Hill and UNC has asked if we are willing to accept this with the Medical Society, with the approval of the Medical Society.

PRESIDENT PASCHAL: You have heard this committee report. What is your pleasure regarding this? Do you have a recommendation?

DR. MCCAIN: I move that we allow them to go ahead. (The motion was seconded by Dr. Bridger.)

PRESIDENT PASCHAL: The motion has been made and seconded.

DR. WELTON: Does your motion include all three?

DR. MCCAIN: Yes.

PRESIDENT PASCHAL: Is there further discussion? If not, all in favor say "aye"; opposed like sign. The motion is carried.

Is there a motion that we approve the annual report of committees?

DR. BEDDINGFIELD: I have one additional, Legislation, if we have time for it.

PRESIDENT PASCHAL: Yes, we do.

DR. BEDDINGFIELD: This will be very brief, and I will not review the things that are in the published committee reports. But from the Committee on Legislation, first of all, as Council knows, regarding our recent annual pilgrimage to the nation's Capitol in Washington, this has been held coincident several years with the United States Chamber of Commerce Conference on Public Affairs.

Council had authorized us to proceed with that venture again this year. However, the United States Chamber of Commerce changed its plans, and this Public Affairs Conference was not held.

There has been some consideration of the Committee on Legislation—and I might add some inquiry from certain of the Congressional delegates offices when you coming to Washington? So with the approval, I believe, of the Executive Committee, Mr. Barnes and myself

have gone ahead and made tentative arrangements for a delegation from the State Medical Society to go to Washington on June 8, 1966, to arrive that day, and to visit with our Congressional delegation who have accepted the invitation on June 9, 1966.

We contemplate an entourage of about 30 people. The arrangements have been made through Congressman Cooley's office, as the Dean of the North Carolina Congressional delegation. They have agreed to meet with us at lunchtime on June 9th. We also have cooperation from the Washington Office of the AMA as to briefing us on the current issue in feelings that they have gleaned from our Congressmen. Most of you who have made these trips have heard it said "Are you going to come back when Medicare is no longer a big issue?"

The Congressmen are also aware of the fact that our group will be in town that day, and will expect visits from their constituent doctors that day in their office.

Tentatively, the itinerary I suppose is that we have a block of rooms reserved at the Statler Hilton in Washington, 30 rooms for doctors to arrive on June 8th. We have a breakfast scheduled in the New York Room of the Statler Hilton for somewhere between 30 and 35 people. At that time, we would contemplate briefing the group that goes up on what plans for the day are; also briefing from a Washington office of the AMA from Dr. Lester and his staff; and then we would go over to the Capitol that morning to do what visiting we could in the offices; and then we would have a luncheon meeting with the Congressional delegation.

MR. BARNES: At the Congressional Hotel.

DR. BEDDINGFIELD: Just off Capitol Hill there. And then depending upon each individual's time of departure, that afternoon would be time for further visiting in the offices.

I would like for the Council to endorse this project of the Committee on Legislation, and I would like some action along these lines.

When the Council had authorized—this was budgeted for the Committee on Legislation when we planned to attend the Public Affairs Conference of the Chamber of Commerce. There was a \$25 tuition fee, which was budgeted that we would pick up the tab, that each individual would pay his own expenses.

Now we have no tuition fee, and I don't know whether we want to offer any partial defrayment of those. I think they are performing a service for all the doctors of the State. But we would yield to the wishes of the Council.

But we want to know who is going. We all geographic and all Congressional districts of the State represented. We want Society leadership represented. And we have a request from the Hilton, Statler-Hilton, to let them know two weeks in advance the names of the people who are coming.

Now this is scheduled for June 8th, which is not a long way off. I would appreciate discussion and action on this particular measure.

DR. WELTON: I would like to make a motion that we endorse this pilgrimage, or whatever term Dr. Beddingfield prefers. Seriously I think it's very im-

portant for the reasons he mentioned. In my motion, I would like to include \$25 allowance to be given to each of the members who make the trip toward their expenses.

PRESIDENT PASCHAL: I'm not trying to influence your motion, but I raise the question about the adequacy of \$25.

DR. BEDDINGFIELD: It wasn't intended to be full compensation.

DR. WELTON: It's the same amount offered under the previous plan. We all know it's not adequate.

PRESIDENT PASCHAL: Is there a second to this motion that the Council endorse Dr. Beddingfield's request, and that we provide \$25 toward defraying the expenses?

DR. BEDDINGFIELD: I would like some discussion on whether you want to leave it up to the discretion of the President, the new President, and his Chairman of the Legislative Committee, as to who goes on this, or whether any direction should be given to us.

PRESIDENT PASCHAL: Dr. Beddingfield suggested earlier that we have geographic representation, certainly district representation, and knowledgeable men, with some leadership who can come back and disseminate information.

I would ask Dr. Beddingfield if he had a recommendation concerning this.

DR. BEDDINGFIELD: My recommendation—I think it would be difficult to settle it here in this meeting this afternoon, and we're going to find people that we would like to have go, for example, people on the Legislative Committee, who can't go; and I think we ought to have the option of picking suitable alternates for them.

I believe if it could be left to the discretion of the President, the Executive Director and the Chairman of the Committee on Legislation—and I'd like to add to that that any of the members of the Council that would be interested in being included on that, let us know, because we might work them in from their district. That would be my recommendation, that it be left to the three people I mentioned.

PRESIDENT PASCHAL: You have heard his suggestion.

I would think it would probably be appropriate for the President to delegate that authority to the Chairman of the Legislative Committee, and let him function in conjunction with the ones he's designated, the President, the Executive Director.

DR. KOONCE: I move his recommendation be accepted.

(The motion was seconded by Dr. Bridger.)

PRESIDENT PASCHAL: That's moved and seconded. Any discussion?

If not, all in favor let it be known by saying "aye": opposed like sign. The motion is carried.

DR. BEDDINGFIELD: One or two other short things on legislation.

We have had correspondence recently with a man who is a friend of ours who, because he has no opposition, will be a member of a State Senate next year, and the chiropractic group has shown increasing

signs of activity of sponsoring new legislation to broaden the Chiropractic Act in the next General Assembly.

I think we have previously reported here that they have circularized the present members of the General Assembly, the 1965 General Assembly, and they will be back on the scene in 1967.

They have also approached John Hendley, who has always been very sympathetic. He's a pharmacist and a friend of ours, and he has no opposition in his bid to be elected to the State Senate from Cumberland County.

Mr. Henley has transmitted information to us. We have a draft of the proposed legislation. We were asked to comment on it. We did comment on it. He turned our comment over to the Chiropractic group, so they have rebutted that. We're sort of in a debate by mail at this stage of the game.

There seems to be no area for compromise or meeting of the minds. This is a continuation of the thing that we discussed before. Mr. Anderson feels—and I concur completely in this—that the time is now when we have before the May primaries, and I wonder whether we ought to discuss this, even though it's a public meeting at the House of Delegates tomorrow.

We feel that we should communicate from State headquarters office to the Committee on Legislation, to the component societies—we have a list, of course, of all of the candidates from both parties for all of the seats in the State House of Representatives, and in the Senate, and to ask individual doctors to ferret out sentiment, to let these candidates know that the doctors are extremely interested in this issue, on liberalizing chiropractic in North Carolina, and we are very much opposed to it.

Mr. Anderson has already compiled a document outlining the historic background of the chiropractic problem in North Carolina. I agree that we should do this. Our effort for 1967 should begin now, and we would like an endorsement from the Council of this type of activity.

I would also like to comment and wonder if this will backfire on us as to anything unfavorable. We could reach a lot of doctors in a lot of counties, if we could discuss this in some way at the House of Delegates meeting, and I wonder if it would be judicious to mention it in an open meeting.

PRESIDENT PASCHAL: You have heard Dr. Beddingfield's remarks about this problem. I'd like to ask Mr. Anderson what he thinks about the discussion of this in the House of Delegates.

MR. ANDERSON: I think you could discuss it very effectively by discussing the importance of the physicians taking some part locally in not necessarily campaigns with one candidate or another, but to let the candidates know of our interest in good medicine, in good medical legislation.

DR. BEDDINGFIELD: Use this as an example.

MR. ANDERSON: You need not discuss the issue directly, but if you could get word back home and take back to the candidates that you are interested in good health legislation, you could approach it generally. I think it would be well worth while. We can circulate

all we can privately and get the word back to your doctors in your districts.

For goodness sakes, if you've got a friend in the legislature, run him for it, and go support him, but generally find out how they all feel about the subject.

PRESIDENT PASCHAL: You have heard Dr. Beddingfield's request that this Council endorse his proposal. He thinks it would add weight to his operation. Is there a motion that the Council endorse his proposal as suggested by Dr. Beddingfield.

DR. BRIDGER: I make a motion to endorse it.

DR. WELTON: May I ask a question, Mr. President?

PRESIDENT PASCHAL: Is there a second to the motion that we endorse their efforts?

(The motion was seconded by Dr. Williams.)

DR. WELTON: Mr. Anderson didn't finish the question that I thought was in his mind. What risk is there in speaking about this openly at the House of Delegates?

MR. ANDERSON: I don't see any risk in speaking about the chiropractic problem, whether the press is there or not.

DR. WELTON: I don't either. The chiropractors are on television advertising. We had darned well better get this out in the open and get our members informed and doing something about it.

MR. ANDERSON: I think this should be one example, because we're going to have other examples. This is not going to be the only problem. But I see no hesitancy at all in discussing it openly.

PRESIDENT PASCHAL: Would it be appropriate to ask Dr. Beddingfield his activities with the Committee on Legislation to develop this and encourage the members of the House of Delegates to get to work on the matter?

DR. KERNODLE: I think this should be a separate item. It's so important that you can't leave it under a bush, and when he reports on the Legislative Committee, there's going to be a lot of them passing on through the whole thing.

I think it should be brought out as a very definite entity.

DR. BEDDINGFIELD: I won't mention all the things in legislation, because they're in the Compilation. These are things not in the Compilation that will be special items.

DR. KERNODLE: You can't run it all together with the routine report. Half of them will pay little attention to the whole thing. This is the kind of thing we've got to stand up and be heard about. It should be heard in the open session.

PRESIDENT PASCHAL: We can ask that our Speaker separate it and bring it on the floor as a separate matter.

DR. RHODES: Mr. Chairman, I would like to make one little statement here about Medpac. Our objectives are pitched largely on a Congressional level; but one of our main objectives is to get our people at the local levels involved in political activity, and we do not restrict that activity to Congressional candidates.

So that one of our main objectives in Medpac now is to try to get our local people at the local level involved in political activity. And if anyone here has a

suggestion as to how we may further that, we'll be glad to hear from them.

MR. ANDERSON: That was one of my ideas, and Ed's, to get this before the House of Delegates, not just on chiropractic, but interested in their candidates and their friends, because you don't have to talk about chiropractic just because you have a friend in the legislature—they'll visit.

DR. SUMMERLIN: You've got to get something to stir them up though, John. These generalities are fine, but don't beat legislation.

MR. ANDERSON: I think there were 27 who voted against us. I don't think it's that important to single out those who did.

DR. THURSTON: We were interested in knowing who voted against us last time.

DR. BEDDINGFIELD: The candidates for both Houses and both parties, Mr. Anderson would be glad to go over it with you.

MR. ANDERSON: I can pick out the ones.

PRESIDENT PASCHAL: We have endorsed that and voted and passed it.

DR. BEDDINGFIELD: I have one small item that will take thirty seconds.

This is another perennial problem, and I don't think this requires any action at this time. But we are again and continually faced with the enigma of podiatrists or chiropodists prescribing potent medications, and we have had another communication and a review of all the Attorney General's decisions and court rulings on it.

We have had some letters from physicians, a number from pharmacists. There is a most recent case; Mr. E. Harris Smith, Jr., pharmacist at Thorn's drug store in Tarboro, someone called the pharmacy for a chiropodist to issue a prescription. He state he had refused prescriptions from a chiropodist's call for chloromycetin, and one for emperin Compound No. 4. He said the chiropodist called him and protested the refusal to fill the prescriptions, whereupon he gave me some of the background of the case.

The patient was a diabetic, developed gangrene of the foot, hospitalized for treatment; but when it became evident the foot must be amputated, the husband removed her from the hospital and carried her to the foot doctor in Rocky Mount, who accepted the case for treatment and prescribed the chloromycetin and emperin.

We have these letters all the time. Our concern, and the concern of the Board of Pharmacy, is really two different things. We're concerned about the public interest of prescribing potentially very potent and perhaps harmful medication, such as chloramphenicol, and so forth, to pharmacists. The Board of Pharmacy is concerned about the legal liability of pharmacists in handling these. It's a different area of concern.

Mr. Anderson and I have been in direct communication about it. We have said before in these meetings that we don't know whether the proper avenue is to seek legislative or judicial relief. It almost appears that you have to wait until you have some good cases to go on.

I don't know any action we can take. We are seeking

all the help we can get. We conferred about it frequently, but I thought the Council ought to be aware that this is part of our activities.

PRESIDENT PASCHAL: Thank you, Dr. Beddingfield. I think this will be accepted for information.

Is there any addition to the report of the committees as tabulated and compiled in the Compilation?

I would call your attention to the Utilization Review Committee. Dr. Fuller is going to have a meeting here on Monday afternoon at 4:00 p.m. Those concerned I hope will be able to participate.

We have with us this afternoon the Chairman of the Joint Advisory Council on Chronic Illness and Aging, Dr. Tom Nichols. Do you have any comments that you would like to bring to the Council?

DR. NICHOLS: Mr. President, I have no formal comment. I am here to monitor the feeling of the Council, so that it might be transmitted in a reasonably proper manner as possible to the Joint Committee.

We, as you know, have had some questions. I have met with several individuals. By the way, for those of you who are not familiar with the facts, the Joint Committee on the Health Care of the Chronically Ill and Aged—I have just become Chairman of it through the great vacuum created by the withdrawal of John Kernodle, who has done a perfectly marvelous job for several years, and it is with some tremulousness that I face it.

But the general consensus is that the committee should be continued. It should preserve its status at least for the time being, and that is exactly what we plan to do, and we welcome any suggestions you might have for it.

I might add that we had this two-day meeting organized by D. A. McLaurin, who is Chairman of the Chronic Illness Committee, and I think it was most successful from the points of view that I have had, and it required a good deal of work on his part. These two committees jointly sponsor that.

PRESIDENT PASCHAL: Thank you very much, Dr. Nichols. We're glad to have you here, and we accept this as information.

Is there a motion to accept the reports?

MR. BARNES: I understood that Dr. McLaurin would be here this afternoon to maybe discuss some proposal for regional or district meetings on Medicare similar to the meeting on February 18 and 19, which was, as Dr. Nichols has pointed out, a very successful educational enterprise, on Public Law 89-97.

I think there has been some general recommendation that there be some additional meetings at a lower level, and I thought that he would be here this afternoon to report, but he hasn't arrived.

PRESIDENT PASCHAL: This is primarily for educational purposes, for the development of leadership capabilities.

MR. BARNES: I think it's going to involve some funds. Didn't he discuss that with you?

PRESIDENT PASCHAL: We talked briefly about this the other evening, for this to be instituted and developed, and for him to develop his proposed program of having regional conferences will require the use of

some funds of the Society. I don't have specific figures on how much he wants.

MR. BARNES: I don't know either.

PRESIDENT PASCHAL: I got the impression that the overall program in North Carolina would amount to anywhere from \$500 to \$1,000.

This program for dispersing information, creating leadership, I think would pay big dividends. I'm sorry he's not here to speak further to this. He didn't provide me with any specific information about it.

Ed, do you have any comments on this phase of his suggestion?

DR. BEDDINGFIELD: I think this relates to Dr. Welton's suggestion that we need every avenue of communication that we can to physicians. I think the State meeting was well attended and was really quite a successful meeting.

I would think that this is important enough that some sort of endorsement in principle be given by the Society. Dr. McLaurin was to develop a series of alternate proposals for this Council for this afternoon, and I'm not sufficiently informed as to the details of the various alternates to discuss them intelligently.

I would think this is the sort of thing, if we endorse it in principle, of improving communications through a series of regional meetings, and have this prepared in writing and circularize the Council by mail, that this would dispatch this particular item of business.

PRESIDENT PASCHAL: One of the things suggested was that we might try to do it on a county level. We thought that that would impose a great hardship on the individuals participating in these programs, and that it might not be feasible.

I don't, as I told you earlier, know how much money is involved. I get the impression it's between \$500 and \$1,000. And while I wouldn't want to ask you to commit yourself for any particular amount of funds, it might be well, in order that this program might be developed, for the Council to go on record as approving it in principle and let it be worked out as it does develop.

Is there a motion to that effect, that we approve this in principle?

(Such a motion was made by Dr. Welton and seconded by Dr. Beddingfield.)

PRESIDENT PASCHAL: Is there discussion?

DR. WELTON: Mr. President. I think that several counties are already scheduling programs on this in July, and if we don't develop something regionally, the talent would be spread too thin than it could be if several counties got together for a meeting of this type.

So I think it's important to keep trying to develop some setup regionally.

PRESIDENT PASCHAL: Further discussion? If not, are you ready for the question? All in favor let it be known by saying "aye"; opposed by like sign. The motion is carried.

Now is there anything else pertaining to the reports of the committees? Jim, do you have anything more?

MR. BARNES: No, sir.

PRESIDENT PASCHAL: All right; is there a motion that we accept the reports of the committees as sub-

mitted in the Compilation and further added to here today?

(Such a motion was made by Dr. Duck, and seconded by Dr. Birdger.)

PRESIDENT PASCHAL: Any discussion? If not, all in favor please say "aye"; opposed? It is carried.

We will move on to Item 10, sub-item (a). Dr. McLaurin had hoped to be here for this.

MR. BARNES: This is a communication to Dr. McLaurin, and I will read it if you want me to do so.

This is a letter dated April 14, 1966, from the North Carolina Pharmaceutical Association, signed by W. J. Smith, Executive Secretary, and directed to Dr. McLaurin:

If you have no specific objection, we will use the word "kit" instead of "box" as applied to emergency drugs for nursing homes. Our reason for this suggestion is that "kit" is being used on a national basis.

We commend you and your committee for your prompt action in meeting an existing need, which will expand as additional nursing homes are opened throughout the State.

The exhibit for the Medical Society meeting in Asheville is being constructed and will be ready by May 1st. Dr. Beddingfield has been helpful in preparing a suggested list of drugs to be included in the kit, but visitors to the exhibit will be given an opportunity to suggest additions or deletions to our preliminary list of drugs.

Mr. McAllister is working on the narcotic problem.

Your project, as it relates to nursing homes, is brand new. So far as we can ascertain, no medical, pharmaceutical, or allied group has come up with such a practical solution to emergency drug supply in nursing homes as has the committee from the Medical Society of the State of North Carolina. It is our hope that Mr. Barnes will recognize this progressive action by your committee while the Society is in session in Asheville.

PRESIDENT PASCHAL: Dr. Beddingfield has been involved with this too. Do you have any comment on this?

DR. BEDDINGFIELD: What this is all about is this, Mr. President: Among the various requirements for

extended care facilities or nursing homes to participate in Medicare, there had to be some provision for emergency drug supply in extended care facilities, and there was a request—I guess it came from either the Board of Pharmacy or the State Board of Health, because there is no definite set of regulations for handling drugs in nursing homes, which of course are licensed from the State Board of Health here in North Carolina now and yet there had to be some mechanism drawn up.

So a meeting was scheduled and attended by the State Board of Health, by the Board of Pharmacy, the Pharmaceutical Association, and the State Medical Society, and I believe the Nursing Home Operators also, regarding the development of some mechanism for legally providing emergency drugs.

The thought seemed to be that as time goes along, possibly we'll see a different type of patient being cared for in extended care facilities; instead of being the chronically ill, these may be people who are convalescing from a myocardial infarction or surgery, and they will be in there only for a couple of weeks, or three weeks, instead of long-term care patients. There is a possibility that unanticipated emergencies in such convalescent patients that would arise would demand immediate availability of certain emergency drugs.

So some research was done on this as to what is being done in other institutions in North Carolina now, and a sample emergency drug box was carried to this committee, and it is anticipated that it would work this way:

In a nursing home or extended care facility, they would have a box emergency drugs which is supplied from their local retail pharmacy. The box is sealed. That a list of the drugs that's in there is on the cover of the box. Its contents are generally known to physicians who would have patients in that extended care facility. The patient would have an emergency arise, such as arrhythmia or fail in blood pressure, or some other emergency, that would be amendable to one of these drugs.

The physician could telephone to the nurse at the nursing home and say "Give 1 cc of aramine," or whatever, and by the time he goes to see the patient, there would not be sufficient time with this class of patient to procure such drugs elsewhere.

It is anticipated that once the seal is broken that the kit would then be returned to the retail pharmacy for restocking and resealing. This suggestion caught the fancy of the committee, and they adopted it. There is some legal difficulty in providing narcotics. The nursing homes do not want to have to be, or perhaps they cannot be licensed as institutional custodial agents of narcotics, and Mr. McAllister of the State Board of Pharmacy has carried on extensive correspondence with the Treasury Department of the Bureau of Narcotics to try to find a legal mechanism, maybe one or two ampules of demerol for emergency use to be legally incorporated in this box.

I don't know anything further to report about it. I believe there is an exhibit here, and the drugs that are incorporated in the box represent the thinking of only maybe three or four individuals, and perhaps others of you would have very different ideas as to what really would be emergency drugs in certain people, and the State Board of Health would invite your attention to this exhibit for suggestions of additions or deletions.

MR. ANDERSON: Have you worked out the legalities with the Attorney General under the pharmacy law?

DR. BEDDINGFIELD: Yes. It's all legal as far as the known narcotic drugs go. The way it would work is if I ordered a drug and they used it out of this box, then I would write a prescription for this the next morning, and the box would be restocked with that missing item. That's considered to be all right.

PRESIDENT PASCHAL: I think this is largely a

matter of information and it won't require any action at this time.

Now we'll pass on to Item 11, old business. Is there any old business to come before the Council?

Item 12, any unfinished business?

Item 13, new business.

Sub-item (a), Mead Johnson offer of speakers "Current Concepts in Cancer Chemotherapy." We have a communication.

MR. BARNES: This is a letter received on April 25th from Dr. Max D. Davis, Associate Medical Director of Mead Johnson Laboratories, directed to the Medical Society of the State of North Carolina.

Dear Sir:

We should like to advise you of a program which we are instituting, and which will be available to you in the coming two years. We have contacted a number of eminent men who are highly qualified to speak on the subject of "Current Concepts of Cancer Chemotherapy." They have indicated their willingness to accept your invitation to speak on this subject at your Annual State Meeting. If you want to take advantage of this program, let us know, so that we can provide you with a list of speakers from which you may choose.

You will handle all of the arrangements to obtain a speaker from the list provided, and we will reimburse him for his expense and will provide him with an honorarium of \$200.

This program was very well received by the speakers, and their physician audiences several years ago, and we are certain that this rerun will prove very popular. Many new cancer chemotherapeutic agents have been developed recently, and much more has been learned about the use of the older compounds. Some of the newer techniques and the newer combination of drugs hold considerable promise for treatment of cancer and even cure in some instances.

We hope we can help disseminate this information by providing you with this opportunity to obtain a qualified speaker at our expense. If you desire further information or have any questions at this time, please let me know.

I would think that there are two things involved. Of course choosing from a list of proffered speakers would certainly lie in the purview of the Committee on Scientific Works, and I think you might very well acquire the list and refer it to the Committee for study and then consideration and recommendation maybe at the Fall Conclave.

And the second thing is that this is a pretty hefty honorarium as compared to what the Medical Society pays from its budget as honorariums, and you might be setting some sort of precedent and hook you with your own honorariums. There are two possible implications.

PRESIDENT PASCHAL: Do you think it would be appropriately referred to our Committee on Scientific Works?

MR. BARNES: Yes, I do. I think we ought to go ahead and acquire the list just as a matter of infor-

mation, and when the new Committee on Scientific Works is designated by President Jones, that this list be referred to them, and they can consider it and come up with any recommendations they want to make to the Council in the Fall.

PRESIDENT PASCHAL: Is there a motion that we do that?

(Such a motion was made by Dr. McNeill and seconded by Dr. Duck.)

PRESIDENT PASCHAL: Any discussion? If not, all in favor say "aye"; opposed by like sign. The motion is carried.

Item 13 (b) Rural Health Committee desire to sponsor State Rural Health Conference, Fall of 1966.

MR. BARNES: Please bring to the Executive Committee for their action the desire of the Rural Health Committee to sponsor a Rural Health Conference this Fall. It might be worth while to mention that no obligation will be made to furnish meals.

I guess there would be some expense involved in the program, and that sort of thing.

PRESIDENT PASCHAL: You have heard this communication. I would assume that they would want direction from the Council to proceed with the planning for this.

DR. KERNODLE: Isn't the Rural Health Council of the AMA going to have their annual meeting in Charlotte this Fall?

MR. BARNES: No., 1967.

PRESIDENT PASCHAL: Is there a motion to approve this?

DR. BRIDGER: I move it be approved.

PRESIDENT PASCHAL: It's moved that this be approved. Is it seconded?

(The motion was seconded by Dr. Koonce.)

PRESIDENT PASCHAL: Any discussion? All in favor please say "aye"; opposed by like sign. Motion carried.

Item (c) National Conference Infant Mortality Problems—San Francisco.

MR. BARNES: This is in reference to the American Medical Association's Committee on Maternal and Child Health, and a Conference on Maternal and Child Health arranged to be held on the subject of infant mortality problems scheduled for August 12th and 13th in San Francisco, California.

They have requested that the State Medical Society send representatives from its Maternal Health Committee, and from its Child Health Committee to participate in that conference.

I have communicated this request and invitation of the AMA to both the Chairman, Dr. R. S. Kelly, the current chairman, and Dr. Joe May, the current Chairman of the Committee on Maternal Health, and both are inclined to think that this is an important meeting, and would be willing to go, but obviously couldn't go without a designation for expense.

It is brought to you from the standpoint of what do you want to do to support this AMA request for state participation in the Medical Society?

PRESIDENT PASCHAL: You have heard this request. What is your pleasure?

It costs \$500 to fly there and back.

DR. BRIDGER: Do you have the money?

PRESIDENT PASCHAL: Dr. Donnelly is on the National Committee and will attend. It might be that he could have a dual purpose while attending.

DR. MURPHY: Do we need anybody additional in the light of that?

MR. BARNES: They wanted a representative of the Committee on Child Health and Committee on Maternal Health. They wanted two.

DR. MCNEILL: These are two fine organizations, and the Chairmen of our committees devote a lot of time and effort to what they're doing, and I think they have done a tremendous job. Even though I'm just a Vice Councilor, I'd like to recommend that the Society support it.

DR. THURSTON: Not to the extent of the full expense, but they might share the expenses, underwrite the full expense up to a certain amount.

PRESIDENT PASCHAL: We talked earlier today about supporting representatives of the Society on such official missions.

DR. BRIDGER: I make a motion that they be sent.

PRESIDENT PASCHAL: With Society funds? That would be two representatives, one from the Infant Mortality and one Maternal Care.

(The motion was seconded by Dr. McNeill.)

DR. GLASSON: I don't mean to take away from the worth of these two committees, but we have some 80 committees and we have a lot of conferences all over the country, and I don't think that the Society can undertake to send committee chairmen to meetings all over the country as a precedent; and therefore I would vote against this measure, particularly in view of the fact that we have Dr. Donnelly already at the meeting.

PRESIDENT PASCHAL: You have heard these comments.

DR. JONES: I would be concerned about the economics of this thing, because San Francisco and back for two people is not cheap.

PRESIDENT PASCHAL: It would cost about \$1,000. Do you make a substitute motion?

DR. GLASSON: No, there's a motion on the floor and I'm just speaking against it.

PRESIDENT PASCHAL: You have heard the comment. Is there further comment? If not, are you ready for the question?

All in favor of this motion that the Society underwrite the expenses of two representatives to attend the San Francisco meeting let it be known by raising your right hand. Those opposed? The motion is defeated.

We will ask Dr. Donnelly to bring us information concerning this particular meeting.

Now we go to item (d), Sampson County Health Department.

MR. BARNES: This is a carbon copy of a communication from the Secretary-Treasurer of Sampson County Medical Society. It bore no date, but we received our copy of it on the 7th day of April, 1966, and it's addressed to Dr. Caroline Callison, Director of the Sampson County Health Department.

At the February 23, 1966 meeting of the Sampson County Medical Society, the problem of school children examinations and treatments on referral from the local Health Department was discussed. It was the unanimous approval of all members present that all school children sponsored under Federal, State, and Local governmental agencies would be seen and examined in the doctor's office of their choice. It was also unanimously approved that the method of fee determination would be in accordance with the 1964 Relative Value Studies as approved by the Medical Society of the State of North Carolina, May 2, 1965. A point value of \$4.00 per point was unanimously approved.

If you have further questions regarding this or any further comments, please reply to me and I will present it to the County Society at its next regular meeting.

With kindest personal regards.

PRESIDENT PASCHAL: I believe this is only for our information. This is just a copy sent to us. I believe it requires no action.

Is there any other new business?

DR. McCAIN: Does that have a special place about routine examinations for school, or is that considered a regular office visit? The examination is very brief. I wonder if there is any special designation in the Relative Value—

DR. JONES: There is not.

DR. McCAIN: Regular office visit.

DR. JONES: Limited visits and attention, and over and above, and so forth, of point value.

PRESIDENT PASCHAL: Is there other new business?

DR. RHODES: Mr. Chairman, I would like to bring one matter that I believe might be considered new business to the attention of the Council for information.

At the last General Assembly, legislation was enacted establishing the Government Coordinating Committee on Aging. This is the first official organization—a previous committee had been in existence appointed by the Governor.

The committee has been organized. In its membership there are seven members appointed from the citizenry of North Carolina by the Governor, and then there are most of the agencies, particularly those concerned with education and welfare, etc., that are involved. The Medical Society has a representative on this committee. Dr. Beddingfield represents the Medical Society.

The committee has been organized under the chairmanship of Senator Roe, and thus far a subcommittee on planning has drawn up a plan to be submitted to HEW, which has the responsibility for administering the old Citizens' Act, which is a new act of Congress, establishing funds for this purpose to match the State funds.

It also has appointed an Executive Secretary to implement the program.

Now this has implications for the Medical Society and for the physicians in North Carolina, in that our own Medical Society Committee on Chronic Illness and Aging

maybe involved in the implementation of this program, and individual citizens at the local level are going to be expected to submit information about aging people in their communities.

So I felt that that was information that this Council should have.

Then one other matter I'd like to mention, and that is I would like to bring you to date on the Association of Professions, which this Council—to which this Council has made a contribution for the last three years of support.

The Association of Professions now comprises the engineers, the architects, the veterinarians, the pharmacists and physicians. During the next year, the program of the Association will be directed primarily toward education, particularly bringing to the attention of prespective young people information about these several professions.

At the present time, three seminars have been already scheduled in community colleges, one in Piedmont, one in Charlotte, one in Southern Pines, and one down in Whiteville.

Other such seminars are planned. So that the objective of the Association of Professions in the next year would be to try to stimulate and to bring young people this information, so that we may help to fill some of the vacuum that is already existing and will become more acute certainly in medicine in the next year or so.

I thought you might be interested in having that information, and I would also suggest to all of you that the dues for this organization of \$5 a year—I believe that there's not a member on the Council here, or a doctor in North Carolina that couldn't afford that. I would say at the present time the pharmacists have far outstripped all other groups. Medicine runs a poor second, having approximately 78 or 80 members as compared to 165 for the pharmacists.

Thank you very much.

PRESIDENT PASCHAL: Thank you, John.

We accept this as information.

Is there any other new business?

DR. GLASSON: Mr. Chairman, I'm sure most of the members of the Council are acquainted with the recent untimely death of Mrs. Baker, the wife of Dr. Lenox Baker, President of the State Board of Health, and Past President of the State Medical Society.

As you may or may not know, Dr. Baker is being honored by the former residents on his program on the occasion of completing 25 years of work in the Orthopedic Department at Duke. This dinner is to be held Monday night with the presentation of a portrait.

I would like to move that the Council forward to Dr. Baker and to the members of his family an appropriate resolution of concern and sympathy on the occasion of Mrs. Baker's death, and congratulations on the completion of this long tenure with the Duke Orthopedic Program.

PRESIDENT PASCHAL: You have heard the recommendation. Would you make it as a motion, that the Council go on record as recognizing his long and significant tenure of service, and also offering our sympathy to him in his recent loss?

(Such motion was made by Dr. Glasson and seconded by Dr. McCain.)

DR. KOONCE: Might I make a suggestion that you appoint a committee to do that right away, and that it be read before the House of Delegates tomorrow?

PRESIDENT PASCHAL: We would like to have this transmitted to him, so that it would be in his hand by Monday evening at the time of his recognition there in Durham.

PRESIDENT PASCHAL: It's moved and seconded. Is there any further discussion? If not, all in favor please say "aye"; opposed? It's carried.

Dr. Styron, Dr. Rhodes and Dr. Glasson to serve on the committee to prepare this.

Is there further discussion?

DR. COGDELL: I don't know whether this is the right time to bring this up or not. If you remember back, you asked me to negotiate with the Veterans Administration relative to their program. We are now operating—I told them I'd have to ask for further instructions from the Executive Council before I could sign it. We wrote the most diplomatic letter we knew and said nothing. I would like to know the wishes of the Council.

PRESIDENT PASCHAL: Did I understand that you asked for what?

DR. COGDELL: The offer is $3\frac{1}{2}$ for the year '67 and '68. It's not a very big thing. It's about \$100,000 a year to the doctors, and I was afraid it was a gimmick to get us to accept a cheap program, and they would want us on some of the bigger programs. We just evaded the thing.

PRESIDENT PASCHAL: You want authorization from the Council—

DR. COGDELL: I want to know the wishes of the Council while I'm up, I'll bring another. Our Committee voted to renegotiate the Medicare, that is the Army dependents only. Then the Council said we'll go by the new schedule. We got that in January. We have gone through the program. We're operating now on surgery for 3.58, operating on obstetrics at 3.58.

I spent four or five hours in the past week talking to the Denver office. No one has a Relative Value Schedule of 5, but the best information I can get, three states have a Relative Value of 4.5. I feel like we can get it, and I feel satisfied that we can get 4.

PRESIDENT PASCHAL: You have heard Dr. Cogdell's remarks.

DR. MURPHY: We have a number of resolutions coming to the House of Delegates. I don't think the doctors are receiving what are usual and customary fees. I think we would be out of place in agreeing to anything less than that.

DR. GLASSON: As far as the discussion and the view of Dr. Murphy, I think that 5 would be—a conversion factor of 5 would be what anybody is charging the private patients for most of these procedures.

I think that 3.5 would be low, but I think that these are not 'way off base for what we would charge private patients, if you look at the fees on the California Relative Value scale.

DR. COGDELL: One other thing. Every time I talk

to those people to try to negotiate, what is thrown back in my face, and we may have made a mistake thinking we're doing right, when you're taking care of the same income bracket on your Blue Shield for such an such a figure—and they have those figures and throw it back at me every time I talk to them; I tell them "Heck, I don't make any different charges to anyone."

I don't have those figures of what Blue Shield is charging to go by. That's the thing they're going to throw at us on everything we try to get a raise on.

DR. RAIFFORD: Dr. Cogdell said the old California Relative Value Schedule—do you mean the '61 or '64?

DR. COGDELL: The '64. The old schedule, the ones that they're operating on. I understand Utah and one other state—and Jim was going to recheck—they have had a sort of war out there in California trying to get it up, because figures did not show the state as a whole.

Now we have written every doctor who has received \$250 in 1965 asking him his usual customary charges for the procedures that he does. About 800 some letters went out, and we have about 450 back; but we haven't had a chance to compile them. We thought we would use that as a basis of argument with them.

DR. RAIFFORD: The point of it is that the California schedule is no longer a schedule; that's obsolete. The State Society here—

DR. COGDELL: '64. We didn't get that to go by since January.

We have gone through that program, what our Medicare program faces on each figure, and then we took the other states' Blue Shield and did the same thing with them, and we may be 'way down in one and 'way up in another. It just doesn't feel like any reason as to the way it goes.

MR. BARNES: I did communicate with the California State Medical Association about their experience and whether or not they had negotiated a new schedule, and I have had no reply from them.

DR. COGDELL: You don't know what they're getting now. I think it's 4.5 on the old schedule.

PRESIDENT PASCHAL: It's my understanding that you and your committee have proper authority to get the best arrangement.

DR. COGDELL: We'll get the best arrangement we can and then ask you.

PRESIDENT PASCHAL: Unless the House of Delegates tomorrow changes that.

DR. COGDELL: We'll present whatever we have to the Council when we can get it. The schedule runs out the first of October.

PRESIDENT PASCHAL: And so your report is submitted for information.

DR. COGDELL: I would like to know how you all feel about the value. If I did wrong or right, I'd like to be told. I wasn't going to negotiate a fee for 3.5.

PRESIDENT PASCHAL: The period of negotiation is still open.

DR. COGDELL: No, the appropriation of money is out, but I think we could probably renegotiate for the

year coming. I don't know. I sort of stayed away.

PRESIDENT PASCHAL: Do you have a recommendation for the Council?

DR. COGDELL: The biggest recommendation I think that we need is one committee who will coordinate all these negotiations. If one government program gets a low fee, they'll poke that at our face every other one we go to.

PRESIDENT PASCHAL: Is there any action that Council wants to take on this today?

DR. COGDELL: One other thing. We do have permission to punish the fee after four years fighting.

MR. BARNES: The present prevailing on DMCP.

DR. COGDELL: We have made 500 copies. If anybody needs a copy, they can have it until the thing runs out, and then we hope we'll get a better one.

PRESIDENT PASCHAL: Does the Council wish to make any expression concerning this? We might well be in a position to make some specific recommendation after the House of Delegates.

DR. COGDELL: Let the thing ride and see what happens.

PRESIDENT PASCHAL: I believe Mr. Barnes has a communication.

MR. BARNES: I simply have a letter of an expression of appreciation by the President of the Chapters in North Carolina for their program here Monday night, and for the support in transporting the students to Asheville and return.

PRESIDENT PASCHAL: I would say that our representatives designated by me to represent the Medical Society have been working closely with the Steering Committee on a so-called executive group of directors of the Heart, Cancer and Stroke Program in North Carolina. Plans have gone apace very well.

Application for planning grant has been prepared and has been submitted on Wednesday morning, General Sessions; the Deans of the Medical Schools and our three representatives of the Medical Society are going to be in a panel discussion, and they will be available at that time for questioning, and I believe you'll get a very good picture of the status of this particular endeavor.

If there are questions you have about it at this time, I'll be glad to try and answer them. If not, this brings us to the point—

DR. KERNODLE: May I inject one thought here? Nothing has been said this afternoon about the potential increase in AMA dues, and don't want to open this subject for a long discussion now, but would like to say that in your folder there was a brief letter of ten pages mimeographed to give you the data as to why there is a need for increasing dues on the AMA level.

I point out two points of interest. One is that the membership dues covers only about 2 per cent of the total income of AMA at the moment; 45 per cent of that is income from advertisements.

I might say that I have had no less than a half dozen people, including an inquiry from the Executive Director, with regard to someone that wrote him regarding the second Journal that you had received

gratis, that is your Specialty Journal, and for those who have had these questions (1) the Specialty Journals have netted in 1935 over \$249,000 income to the AMA, and that's one of the reasons you're given an opportunity to get a second Journal. Because of distribution, you get a higher rate of advertisement, and there is more interest among the advertisers.

And the second point is that the AMA's primarily an educational program for us as a federation, and that this is a method of disseminating medical education to our members.

The question with regard to why is there not a Journal for Obstetrics and Gynecology—this has been asked by the Administration in Washington and the Editorial Boards, and the powers that be apparently on the top echelon of obstetrics and gynecology, and they do not think there is a need for another Journal. So if anybody has asked that question, "why can't I get on OB and GYN Journal," it's the reasoning of the College of Obstetrics and Gynecology hierarchy not wanting one.

I do think that it's like everything else, cost of living, cost of operations going up. I hate to tell you that this week I was in Chicago, and they tell me that approximately 15 per cent of our higher second echelon personnel of AMA are leaving because of better jobs, better positions elsewhere, and the fact that they can get more money in paramedical groups. I don't have to tell you what those groups are. You can reason likewise.

If there are any questions about this this afternoon or during the next 24 hours before the two o'clock meeting tomorrow, I'll try to answer them, or Amos Johnson will likewise.

PRESIDENT PASCHAL: Thank you, Dr. Kernodle.

Is there anything else to come up under new business or to be brought to the attention of the Council?

If there is nothing else, we will entertain a motion for adjournment in just a moment.

I would like to take this opportunity, if I may, to speak to the Council and to the Staff. I have come to recognize something more fully that I knew before I became President, and that is that we have one of the best staff, administrative staff in our headquarters office that is existent in America.

This attitude of mine is shared by Executive Directors across the country, and they are well aware of the great effort and contribution that our Director has made.

I would pay particular tribute to him and express a feeling of gratitude for what he has done, along with Mr. Hilliard and Mrs. King, Garland Pace, Miss Ziegler, and others.

This is something that the succeeding President will appreciate more as the year goes by. I'm sure those of you who have preceded me will reflect and remember the great help that they provided.

It has been with a marked sense of humility that I have been your President. I'm grateful for the opportunity, and I ask that Council support my successor as they have supported me. I'm very grateful.

Thank you. (Applause.)

(The meeting adjourned at 4:50 o'clock.)

HOUSE OF DELEGATES
SUNDAY AFTERNOON SESSION
 May 1, 1966

The Opening Meeting of the House of Delegates of the Medical Society of the State of North Carolina was held in the Asheville City Auditorium, Asheville, North Carolina, at 2:15 p.m., Dr. George W. Paschal, Jr., President of the Society, presiding. President called the meeting to order and the invocation was pronounced by the Reverend John W. Tuton, Rector of the Trinity Episcopal Church in Asheville.

PRESIDENT PASCHAL: It is now my happy privilege to introduce to you our Speaker. Our Speaker has spent years in the service of the Society. He's been one of our distinguished Past Presidents. He is currently a delegate to the American Medical Association, and he is a Speaker par excellence.

I give you Dr. Donald B. Koonce. (Applause)

(Dr. Koonce assumed the Chair as Speaker.)

SPEAKER KOONCE: Thank you, George.

I am going to call for a report of the Committee on Credentials. We have a total of 217 delegates, potentially. It would take a quorum of 108. The House of Delegates consists of those, as you know, elected delegates plus Past Presidents, Past Secretaries, and existing officers at the time. Our total is 217, and a quorum of 108 is necessary.

Dr. Wilkerson, do you have a report yet?

DR. CHARLES B. WILKERSON: We have 112 delegates, officials and councilors certified.

SPEAKER KOONCE: Since we only need 108, I declare a quorum present, and we will proceed with the proceedings of the House of Delegates.

I would like to recognize at the present time the President of the American Medical Association, Dr. James Appel.

(The delegates rose and applauded.)

SPEAKER KOONCE: Next on the agenda is the announcement of the Committee for the President's two speeches. The members of that committee will be Charles Styron as Chairman, Dr. Ernest Craige, and Dr. Marvin Lymberis, and they will go over his speeches and make a report back on Tuesday, as planned.

Now, without any further ado, I would like to introduce a very old and dear friend to me, and this whole Medical Society, to conduct the memorial services, Dr. Charles A. Pugh.

DR. CHARLES A. PUGH: Dr. W. A. Sams will lead us in prayer.

DR. SAMS: Our gracious and ever-loving Father, we approach Thy throne in a spirit of reverence and remembrance, for the lives of those of our profession who have passed to their eternal home during the past year.

May we assembled here join hearts and minds in humble remembrance of their works and loyal support of our profession. May we in all our works begun, continued and ended in Thee glorify Thy holy name. Amen.

DR. PUGH: Once again we hear the tread of the Reaper, as God the Father beckons to our beloved friends and loved ones who only yesterday worked with

us, sympathized with us in our sorrows, and rejoiced with us in our joys.

At this hour we mourn for them, because they were all dear to us and made our journey more pleasant. We have lost their wise counsel, their cheering countenances, their presence here, and the inspiration they brought to us who were privileged to work with them.

Death is a theme not lightly to be broached by those who are subject to its power. The young may die, the old must die, and the wisest knoweth not how soon. There are none that escape the inexorable doom. The youngest child on the rolls of our public school system dwells ever in the shadow of death, while the invisible hand extends equally above the highest officer in the land. We walk upon the ashes of the generations who have gone this way before, and to which our ashes must in turn contribute. It is not for us to hope for an exemption from the common doom of man. What an incentive is this to an industrious use of our time and faculties, that we should build industriously while our strength endures and labor to complete our work ere the week closes and the Sabbath of Eternity sets in.

Those whom we honor today did make a contribution to their age and generation, but they did not complete their work. However, we would pause at this moment and pay loving tribute to those of this Society who have been called to lay down life's battles and to rest from their labors. We would pause reverently in the presence of Him from whom we come and to whom we return, and in whom while we tarry here, we live and move and have our being. In the quietness of our respondent and unfading memories, we are grateful for the good gift of life, for its wonder and its mystery, its interest and joys, its friendship and fellowship. We are thankful for the ties that bind us one to another.

The bodies of these, our friends and co-workers, given to them by God as the Earthly Abode for their Immortal Spirits, have been laid aside with loving and reverent care, but their influence lives on in the service of mankind. Their works do follow them. As their lives were spent in service to their fellowman and in the interest of those who suffer, may we, engaged in similar service, strive always to use our utmost strength in the interest of those for whom we labor.

Fifty-nine members of this Society have laid aside the working tools of life since last we met. We offer these sentiments in their honor and as a tribute to their life of service.

To cure sometimes, to relieve often, to comfort always, is the mission of the healing profession. Soldiers of humanity, and worth followers of Hippocrates, Hail and Farewell.

(A list of the deceased was read.)

DR. PUGH: Heavenly Father, Thou who hast already given so much, one thing more we request of Thee: Give us grateful hearts.

SPEAKER KOONCE: It now gives me a great deal of pleasure to call on a good friend of all of us who has served us with a great deal of dignity to give us the annual message of the President, Dr. George Paschal.

(President Paschal presented an address to be pub-

lished in the May issue of the North Carolina Medical Journal.)

(Applause)

SPEAKER KOONCE: Thank you, George. That message will be turned over to the Committee for Review of the President's Message without discussion.

I would like to request Dr. Theodore Raiford to serve as Parliamentarian. We may need you before we get through.

The next is a report of the Constitutional Secretary. All of these reports are in your Compilation. If there is any discussion, it can be had at this time, and I will ask for any additional reports at this time from the groups.

DR. STYRON: No additional report.

SPEAKER KOONCE: Do I hear discussion? Do I hear a motion that it be approved as it appears within the Compilation?

(Such motion was made, seconded, put to a vote and carried.)

SPEAKER KOONCE: The Executive Director, Mr. Barnes.

MR. JAMES T. BARNES: Mr. Speaker and Members of the House of Delegates: I have nothing in particular to add to the report as obtained in the Compilation for your consideration. The Audit Report for 1965 is of course printed in your Compilation. It was a good year, 1965, and as you can see from the report, there was a net bank balance rather than red.

I might add that for 1966, a budget of some \$280,000 is estimated or anticipated. We have produced \$245,075.18, leaving a deficit to obtain during the remaining seven months of this fiscal period of \$34,941.82. This is as of March 31st, and I'm sure with revenues for April from the Journal and throughout the remaining part of the year that we will far exceed that.

The expenditures authorized for 1966 of \$265,083 as of March 31st has been expended to the extent of \$67,685.05, a difference in your favor of \$197,297. Of course, the annual session and a good bit of the preparation for that would not be included in this expenditure figure at this level.

I present this audit report, the official one, to the House for consideration.

SPEAKER KOONCE: Thank you, Mr. Barnes. Do I hear a motion that his report as listed in the Compilation and any additional remarks be approved.

(Such a motion was made, seconded, put to a vote and carried.)

SPEAKER KOONCE: The Assistant Executive Director, Mr. Hilliard.

MR. WILLIAM N. HILLIARD: No further report.

SPEAKER KOONCE: Do I hear a motion that it be accepted as listed in the Compilation?

(Such a motion was made, seconded, put to a vote and carried.)

SPEAKER KOONCE: Assistant to the Executive Director, Mr. Paris.

Apparently there is no addition.

(A motion to accept the report as printed in the Compilation was made, seconded, put to a vote and carried.)

SPEAKER KOONCE: Education Consultant, Miss Zeigler.

MISS KAY ZEIGLER: No further report.

SPEAKER KOONCE: Do I hear a motion that her report as listed in the Compilation be approved?

(Such a motion was made, seconded, put to a vote and carried.)

I had asked our Vice Speaker to escort our President of the Auxiliary to the dais, but I understand her husband is present, and I don't know of anybody who has any more privilege than he does.

I will ask Dr. Sikes to escort his wife to the rostrum, please. This is always a very pleasant duty, to have the President of the Auxiliary report to us.

(The delegates rose and applauded.)

MRS. C. HENRY SIKES: Mr. Speaker, Mr. President: It is indeed a pleasure to be with you this afternoon, and rather than say I have no report, or nothing to add to my report, just in case you haven't read your homework, I want to review just briefly with you the activities of your Auxiliary.

(Mrs. Sikes reviewed the report as printed in the Compilation.)

(Applause)

SPEAKER KOONCE: Thank you, Mrs. Sikes, for that report.

Her report is listed in the Compilation, and her additional remarks are now open for a motion to approve.

(Such a motion was made, seconded, put to a vote and carried.)

Next we come to a very important part of the program. It is the appointment of the Reference Committee and the reading of resolutions for reference to these Reference Committees.

According to our By-Laws, no resolution shall come before this House of Delegates unless it has been presented in writing to the Central Office sixty days prior to the meeting of the House of Delegates, unless it comes by instruction from the Executive Council, or unless it's read on the floor and approved by a two-thirds vote of the House of Delegates.

Now let's try to keep that in mind. If anybody has a resolution to bring before the House from the floor today, in order to pass it on to the Resolutions Committee, it would have to be voted on by a two-third majority.

There will be two Reference Committees, Number One and Number Two, and according to our By-Laws, the Chairman has to be a Commissioner.

Committee Number One, Dr. Mark Lindsey is Chairman, Dr. John S. Rhodes and Dr. Louis Shaffner.

Committee Number Two, Dr. W. Howard Wilson is Chairman, Dr. Otis Duck and Dr. Hubert Poteat.

Now in the past three has been some question as to whether those presenting resolutions got a fair shake or not, and I think that in all fairness, and because of the importance of these resolutions, that there should be open discussion meetings, and we have arranged to have those two committees have an open hearing tomorrow at twelve o'clock.

Reference Committee Number One will meet in the

back end of the hall. I have a note here from Mr. Hilliard that the entrance referred to is the back end of the hall. There will be a table and arrangements immediately after the General Sessions tomorrow, whereby Reference Committee One will meet in the back hall for a general discussion.

At that meeting, anybody in the State Medical Society has a right to discuss these resolutions that will be assigned to that committee. The committee takes notes, and they meet at their convenience and bring back a report to the House of Delegates on Tuesday.

Reference Committee No. 2 under Dr. Howard Wilson will meet in the front of the stage. The reference committees are open for general discussion at that time. The resolutions presented today will not be discussed. They will be turned over to the Resolutions Committee according to our By-Laws.

Resolution No. 1 to be introduced by Drs. Jones, Beddingfield and Mr. Anderson. Please, if you can leave out the preamble, the whereases, and read the resolveds—unless they are pertinent.

DR. JONES: The committee to draft this resolution was appointed by the Executive Council and the President, Dr. Paschal. The presenter reads only the "resolveds."

RESOLVED, That the physicians, doctors of medicine in the State of North Carolina, and the members of the Medical Society of the State of North Carolina do adopt the posture that when government in any form assumes any financial responsibility for an individual's health care, reimbursement for professional services should be on the same basis as other indispensable elements of health care; therefore, reimbursement for the services of physicians rendering services to persons eligible under government-supported programs should be on the basis of usual and customary fees; and be it further

RESOLVED, That this statement of general posture be also specifically applied in connection with the North Carolina implementation of Title XIX of Public Law 89197 in whatsoever fashion such may be done.

SPEAKER KOONCE: That will be assigned to Committee No. 1. There obviously is nobody here to present Resolution No. 2, so I will read the Resolved, which is the last paragraph.

It is hereby resolved that our medical profession go on record that it is now no longer willing to bear these burdens without full compensation with the usual customary and prevailing fee schedules for Medicare Program and all other governmental-sponsored services. It is recommended that state and local committees be promptly appointed to work out the mechanics of this proposal with the necessary agencies involved. This will require persistent and intensive work if it is realized, but urgent action is requested in order that it may get under way as soon as possible.

That will be assigned to Committee No. 1.

Resolution No. 3, Catawba County Medical Society.

DR. THOMAS E. FITZ: I would like to read parts 1 and 2 of this resolution.

1. That we approve and subscribe the AMA resolution of June 1965 with the following change in the wording of the first line—

That whenever any government agency assumes financial responsibility for an individual's health care, reimbursement for professional services shall be on the same basis of other indispensable elements of health care. Therefore, reimbursement for the services of physicians participating in government supported programs should be on the basis of usual and customary fees.

2. That the Society take immediate steps to abrogate and rescind all existing agreements with reference to negotiated professional charges and further that the Society withdraw its endorsement of all Service plans of insurance.

SPEAKER KOONCE: Dr. Carr, Sampson County, No. 4. That will also go to Committee No. 1.

DR. H. J. CARR, JR.:

It is now the unanimous opinion of this Medical Society that as of July 1, 1966, all members of the medical profession should be paid their full, customary and reasonable fees for all services sponsored by the Federal, State and County governments. It is urged that the Executive Committee approve this resolution and bring it before the House of Delegates of the Medical Society of the State of North Carolina at its annual meeting in Asheville, N. C., April-May 1966. It is also urged that the House of Delegates approve this resolution and that committees be appointed to make satisfactory arrangements to this effect with the appropriate organizations concerned by July 1, 1966.

SPEAKER KOONCE: Thank you very much, sir.

That will also go to Committee No. 1. As you see, as we read these resolutions, a great many of them are similar and by the Reference Committee can be combined, if necessary.

Dr. Mattox from Wilson County.

DR. HUITT E. MATTOX, JR.: In regard to the placement of the AMPAC and MEDPAC dues on the same piece of paper with the dues from the State Society, etc., the members of the Wilson County Medical Society strongly feel that the AMPAC and MEDPAC dues should be very clearly separate and distinct from the State Society and AMA dues.

RESOLVED, That effective with the central billing or Medical Society dues in December, 1966, that solicitation of dues and/or contributions for AMPAC-MEDPAC be included, if at all, on a separate sheet of paper from the statement listing AMA, State Society and local county society dues. It is further resolved that copies of this resolution be mailed to all county medical societies in North Carolina, and that this resolution be presented to the Executive Council with the request that it be transmitted to the House of Delegates for consideration at the May, 1966, annual session.

SPEAKER KOONCE: Thank you very much. That would go to Committee No. 2.

Resolution No. 6, Cleveland County Medical Society.
DR. LIVINGSTON JOHNSON:

RESOLVED, That the North Carolina Medical Society revert to the former practice of billing for its dues and for the AMA dues through the component county societies only, as has been the practice in prior years.

SPEAKER KOONCE: That also will go to Committee No. 2.

Resolution No. 7 from the North Carolina Chapter of the American College of Radiology, Dr. Simmons Patrick.

DR. SIMMONS I. PATRICK: This resolution deals with the separation of fees, of hospital based medical specialists, and presented by the North Carolina Chapter of the American College of Radiology.

RESOLVED, That charges for professional radiology services in the hospital be established, billed and collected by the Radiologists in the same manner as are fees of other physicians; and be it further

RESOLVED, That the Medical Society of the State of North Carolina forward a copy of this resolution to each of its members, to Hospital Care and Hospital Saving Association (the two Blue Cross-Blue Shield Plans of North Carolina), to such insurance carriers it deems advisable, to the North Carolina Hospital Association, and to other pertinent associations, and to include with this a request that they cooperate with the Medical Society of the State of North Carolina in its attempt to effectuate this principle of separate billing.

RESOLVED, That the Medical Society of the State of North Carolina make known its disapproval of any contract or other arrangement whereby a radiologist merges his professional fee with hospital charges.

SPEAKER KOONCE: That resolution will be presented to the Reference Committee No. 2..

Resolution No. 8, Montgomery County Medical Society.

NOW THEREFORE BE IT RESOLVED, That the Montgomery County Medical Society request that the Medical Society of the State of North Carolina recommend to the American Medical Association that it endorse and recommend to the appropriate authorities that space be made available for pertinent personal medical information to be included on the identification cards to be issued to medicare recipients, and that an effective method be developed to see that this information is written in by the users of these cards; and be it further

RESOLVED, That the Montgomery County Medical Society request that the Medical Society of the State of North Carolina recommend to the American Medical Association, and to the National Safety Council that the force and prestige of these groups be utilized to aid and encourage the various states to cause to be published on their respective drivers licenses a form, to be filled in by all licensed drivers, citing pertinent personal medical information which would be necessary should the need for emergency medical care arise.

That will also go to Committee No. 2.

Resolution No. 9, Chowan-Perquimans Medical Society.

IT IS HEREBY RESOLVED, That our medical profession go on record that it is now no longer willing to bear these burdens without full compensation with the usual customary and prevailing fee schedules for medicare program and all other governmental-sponsored services. It is recommended that State and local committees be promptly appointed to work out the mechanics of this proposal with the necessary agencies involved. This will require persistent and intensive work, it is realized, but urgent action is requested in order that it may get under way as soon as possible.

This will go to Committee No. 1.

Resolution No. 10, Rowan-Davie County.

DR. HARVEY ROBERTSON: Our resolution is exactly the same as No. 3. That's why I don't feel the need of reading it.

(See Resolution No. 3.)

SPEAKER KOONCE: Thank you. That will go to Committee No. 1.

Resolution No. 11.

DR. McCAIN (Wilson County):

THEREFORE, the members of the North Carolina Committee on Nursing and Patient Care commend the North Carolina Department of Motor Vehicles and the Committee on Trauma of the American College of Surgeons for this forward-looking step and recommends that every avenue be explored to acquaint drivers with the importance of completing the medical information form on their licenses; and

FURTHER suggest that the state's two Blue Cross Plans explore the feasibility of including similar medical information questionnaire on membership cards; and

FURTHER suggests that the Medical Society of the State of North Carolina consider the possibility of setting in motion through the proper channels a request that similar medical information be included on identification cards to be issued to Medicare recipients.

SPEAKER KOONCE: Thank you. That will go to Reference Committee No. 2.

Resolution No. 12, North Carolina Medical Foundation.

PRESIDENT PASCHAL: Mr. Speaker:

The Executive Council has authorized the incorporation of the North Carolina Medical Foundation, Inc., devoted exclusively to educational, scientific and charitable purposes which are exempt from taxation under the U. S. Internal Revenue Code.

The corporation has been organized, and its Charter and By-Laws have been submitted to the District Director of Internal Revenue for determining that it meets the requirements of the statutory exemption, particularly for the acceptance of contributions and bequests which are tax deductible. The membership of the foundation will consist of the voting members of the Executive Council of the Society, which will elect the directors of the Foundation, who will in turn elect its officers. It will be possible for the

Foundation to construct a building, borrow money for such construction, and to lease part of it to the Society for use by its headquarters staff and to use the other portions of the building for its educational and scientific purposes. The House of Delegates will be asked to approve the implementation of the Foundation and to consider the advisability of transferring some property or funds of the Society to the Foundation for the construction of a building and for use in its activities.

SPEAKER KOONCE: Thank you, Dr. Paschal.

Resolution No. 12 will be turned over to Reference Committee No. 1.

No. 13, Gaston County Medical Society Resolution
DR. FOREST M. HOUSER:

RESOLVED, That the members of the Gaston County Medical Society believe in rendering medical service free of charge to deserving individuals and will continue to do so when indicated.

However, since members of government agencies are paid reasonable salaries for services, and since the hospitals are paid reasonable charges for inpatient care, it seems unreasonable to exclude physicians from receiving reasonable compensation for their services.

Although we believe in paying taxes, we strongly feel that medical expenses incurred by recipients of public help are a public responsibility and therefore should be entirely provided from public funds. When a government forces physicians to accept token fees it is imposing a double taxation on this group.

Therefore, it is resolved that when a government agency agrees to underwrite medical expenses for a segment of the population, it will be expected to pay reasonable fees for medical services.

SPEAKER KOONCE: That will go to Reference Committee No. 1.

No. 14, Buncombe County Medical Society.

DR. JESSE P. CHAPMAN:

BE IT THEREORE RESOLVED, That the Medical Society of the State of North Carolina recommend to the various departments of public welfare that funds be provided in their budgets to compensate physicians for the medical care rendered welfare clients with fees comparable to the usual and customary fees charged by physicians in the community wherein they reside.

SPEAKER KOONCE: That will go to Reference Committee No. 1. Thank you very much.

We have one more item under this, which is a letter to be read by Dr. Paschal.

PRESIDENT PASCHAL: Mr. Speaker, the letter which I have been asked to read is directed to Dr. Lenox D. Baker.

Dear Lenox:

At the meeting of the Executive Council of the Medical Society of the State of North Carolina at Asheville, May 1, 1966, a formal resolution was passed that we express to you our deepest sympathy in your loss of Virginia. It was the wish of the Council, furthermore, that you be informed of

the sincere affection for you and concern for you and your family.

SPEAKER KOONCE: That was written to Dr. Baker by a committee appointed by the Executive Council and that will be accepted as information.

DR. SAMS: Mr. Speaker, I would like to make a motion for this House of Delegates that letter be accepted as a House of Delegates letter, and the Executive Secretary be instructed to forward it to Dr. Baker.

SPEAKER KOONCE: Dr. Sams, that will be forwarded as coming from the Executive Council; but if you want it also to come from the House of Delegates, the motion is on the floor. Is there a second?

(The motion was seconded.)

Any discussion? All those in favor let it be known by saying "aye"; opposed "no." The "ayes" have it and such action will be taken.

PRESIDENT PASCHAL: This resolution is a resolution drawn by a committee composed of Dr. John S. Rhodes, Dr. John Glasson, and Dr. Charles W. Styron, and they were instructed by the Executive Council to prepare this resolution to be submitted here today.

It's a resolution honoring Lenox D. Baker, M.D.

Whereas, Lenox D. Baker, M.D. has served medicine in North Carolina and in the nation as medical educator, orthopedic surgeon, administrator, and advisor for many years with energy, proficiency, and distinction, and

Whereas, Lenox D. Baker, M.D. is held in high esteem by members of the medical profession for his distinguished career, now therefore be it

RESOLVED, That Lenox D. Baker, M.D. herewith receive our heartiest congratulations on the occasion in his honor given by former members of his resident staff on May 2, 1966.

BE IT FURTHER RESOLVED. That Lenox D. Baker, M.D. be accorded our best wishes for a long, productive and happy future.

SPEAKER KOONCE: That resolution will be referred to Reference Committee No. 1.

Next, Item B, Report of the Councilors.

(Vice Speaker Garrard assumed the Chair.)

VICE SPEAKER GARRARD: We start with the report of the Councilors.

First District, Dr. William H. Romm.

DR. WILLIAM H. ROMM: No additional report.

VICE SPEAKER GARRARD: These reports are printed in the Compilation, Pages 16 to 18.

Is there a motion that the First District report be accepted?

(Such a motion was made, seconded, put to a vote and carried.)

Report of the Second District, Dr. Lynwood E. Williams.

DR. LYNWOOD E. WILLIAMS: No additional report.

(A motion to accept the report was made, seconded, put to a vote and carried.)

VICE SPEAKER GARRARD: Third District, Dewey H. Bridger.

DR. DEWEY H. BRIDGER: No further report.

(A motion to accept the report was made, seconded, put to a vote and carried.)

VICE SPEAKER GARRARD: Report of the Fourth District, Dr. Edgar T. Beddingfield.

DR. EDGAR T. BEDDINGFIELD: No further report, and I move the report as it appears in the Compilation be accepted.

(The motion was seconded, put to a vote and carried.)

VICE SPEAKER GARRARD: Fifth District, Dr. Summerlin.

DR. HARRY H. SUMMERLIN: No further report, and I move it be accepted as set forth in the Compilation.

(The motion was seconded, put to a vote and carried.)

VICE SPEAKER GARRARD: Sixth District, John Glasson.

DR. JOHN GLASSON: No additional report.

(A motion was made that it be accepted as printed was made, seconded, put to a vote and carried.)

VICE SPEAKER GARRARD: Seventh District, Dr. David Welton.

DR. DAVID G. WELTON: No additional report.

(A motion to accept the report as printed in the Compilation was made, seconded, put to a vote and carried.)

VICE SPEAKER GARRARD: Eighth District, Dr. Shaffner.

DR. LOUIS SHAFFNER: No additional report.

(A motion to accept the report as printed in the Compilation was made, seconded, put to vote and carried.)

VICE SPEAKER GARRARD: Ninth District, Dr. T. Lynch Murphy.

DR. T. LYNCH MURPHY: No additional report.

(A motion to accept the report as printed in the Compilation was made, seconded, put to a vote and carried.)

VICE SPEAKER GARRARD: Tenth District, James S. Raper.

DR. JAMES S. RAPER: No additional report.

(A motion to accept the report as printed in the Compilation was made, seconded, put to a vote and carried.)

We come now to the report of the delegates to the American Medical Association.

Dr. Elias Faison could not be present.

Dr. Amos Johnson, do you have any report?

DR. AMOS JOHNSON: There is no additional report.

VICE SPEAKER GARRARD: This is printed in the Compilation, Pages 46 to 53.

Dr. John R. Kernodle?

DR. JOHN R. KERNODLE: No additional report.

VICE SPEAKER GARRARD: The report is printed for your information.

(Dr. Koonce resumed the Chair as Speaker.)

SPEAKER KOONCE: Now a report of related organizations. You have those in your Compilation, and we would call for additional reports.

North Carolina Board of Medical Examiners, J. J. Combs. Do I hear a motion it be approved as written?

(Such a motion was made and seconded, put to a vote, and carried.)

Hospital Saving Association, any further report? If not, do I hear a motion that it be approved as written?

(Such a motion was made, seconded, put to a vote and carried.)

Hospital Care Association, no additional report. Do I hear a motion to approve?

(Such a motion was made, seconded, put to a vote and carried.)

Medical Care Commission? No further report.

(A motion to approve the report as written was made, seconded, put to a vote and carried.)

American Medical Education Research Foundation, Dr. Underwood. Any further report?

DR. HARRY B. UNDERWOOD: No further report.

(A motion to approve the report as set forth in the Compilation was made, seconded, put to a vote and carried.)

Report of the Committee on Constitution and By-Laws, Dr. Louis Shaffner.

DR. LOUIS SHAFFNER: Mr. Speaker, members of the House of Delegates: You have a copy of this report that you may wish to follow as we read it. There will be two additions which I will read to you when you get to that part.

Your Committee on Constitution and By-Laws has considered several suggested changes in the Constitution and By-Laws and herewith submits its comments and recommendations:

Change in the Constitution, Item 1: This change was proposed and presented to the House of Delegates last year and along with the By-Law changes of last year will assure that only the active physician members of component county societies shall be the active members of the State Society.

Amend Article IV, Section 2 of the Constitution (page 2) by inserting between the words "the members" the word "active."

The Section will then read:

Active members of this Society shall be the active members of the component societies, and those physicians who are admitted by the Executive Council as hereinafter provided.

Mr. Speaker, will you discuss the vote on this please?

SPEAKER KOONCE: Gentlemen, there is a little parliamentary hitch up here.

According to our Constitution, all the changes in the Constitution on the second reading for ratification, why the component county medical societies have to be circularized sixty days prior to meeting. This was not done. I have checked into this, and we cannot suspend the rules, which I had hoped we could do, because the Constitution should not be written so that it can have any suspension of it.

And the other thing is that you cannot suspend anything in the Constitution which necessitates a circularization, because it's protection for those who are absent.

However, unless I hear objection, I will rule from

the Chair that your Compilation, which was sent to all of the component societies and members will serve as notice of circulation.

Let me explain this much to you. This will not change a great deal. If you will remember the original Section 2, it read "active members of this Society shall be the members other than scientific members."

Last year we ratified marking out "other than scientific members." At least year's meeting, the House of Delegates, the word "active" was added before "members."

It has been passed at the first reading last year. If you will allow me the privilege of my ruling, we can act on it today. If not, we will have to act on it next year.

DR. HUBERT POTEAT: Mr. Speaker, I move you, sir, that the ruling of the Chair be affirmed by the House of Delegates.

(The motion was seconded by several delegates.)

SPEAKER KOONCE: Any discussion? All those in favor let it be known by saying "aye"; opposed "no." Carried.

DR. SHAFFNER: Mr. Speaker, I move, therefore, that this change in the Constitution be approved as read.

SPEAKER KOONCE: Any second to this motion?

(The motion was seconded.)

Any discussion? Those in favor let it be known by rising. The Chair rules that that's two-thirds.

DR. SHAFFNER: Item 2, under changes in the Constitution, is not on your printed list. This was recommended and discussed at the Council meeting yesterday.

This recommendation is that the provisions for the election of the members to the Board of Medical Examiners which is usually held at the last General Session, but which according to the Constitution as now written says the Second General Session—that these changes be made so that we can carry on as has been done since 1961, having these elections at the last General Session.

Therefore, it is recommended that we amend Article IX, Section 1, Page 7 of the Constitution by changing the word "Second" in the last sentence to "last," so that the last sentence will read "The election shall be held on the last day of the annual meeting . . ." etc.

Mr. Speaker, I move that this be accepted as having been presented before the House of Delegates, and to lay on the table for a year and to be voted on next year.

SPEAKER KOONCE: This is for the Board of Medical Examiners. The motion has been made. Is there a second to this motion?

(The motion was seconded.)

Any discussion of it? Those in favor let it be known by saying "aye"; opposed "no." Carried.

This same situation exists with the Editorial Board of the Journal, but since it has not been referred to the Reference Committee, it will have to be referred to the Committee, and the Committee will bring up a recommendation at the next meeting to be passed next May with ratification the following year.

So passed.

DR. SHAFFNER: We now come to the changes in the By-Laws.

These proposed changes are presented today but must lay on the table one day, that is until the second meeting of the House of Delegates, May 3rd, before a final vote is taken, a majority vote being required for passage.

Item No. 1: Amend Chapter VI, Section 5 of the By-Laws (page 18) by changing the words "Assistant Executive Secretary" to "Assistant Executive Director." This merely changes the wording to make it consistent with other wording in the section describing the duties of the Executive Director and his assistant.

Mr. Speaker, I move that this proposal be accepted to lay upon the table and be voted upon at the next meeting of the House of Delegates.

(The motion was seconded.)

SPEAKER KOONCE: Any discussion? Those in favor let it be known by saying "aye"; opposed "no." As you know, motions on Constitution require two-thirds, and the By-Laws only a majority. think our motion for the Board of Medical Examiners, I did not request a two-thirds vote, and I'm going to accept that, because in my opinion two-thirds of the delegates voted for it.

DR. SHAFFNER: Item No. 2: The Secretary of the Society and each of the Councilors and Vice-Councilors are elected for terms of three years. Provision has been made that the Vice-Councilor shall succeed to the office of Councilor should the incumbent Councilor for any reason be removed from office. No provision has heretofore been made to fill any vacancy in the offices of Secretary or of any of the Vice-Councilors should it occur between meetings of the House of Delegates, nor more often than every three years.

The following three proposed changes would empower the Executive Council to fill any such vacancies until the next meeting of the House of Delegates and would instruct the Committee on Nominations to submit to that next meeting of the House of Delegates names of nominees to fill the unexpired terms of those vacant offices.

(a) Amend Chapter V, Section 2 (page 16) by adding to the last sentence so that it will read:

"The nominations for the ten (district) Councilors and ten (district) Vice-Councilors, and the Secretary shall be made each third year, except that nominations shall be made in any year as necessary to fill the unexpired terms of any such offices that may become vacant since the last meeting of the House of Delegates."

(b) Amend Chapter VI, Section 4 (p. 17) by adding this sentence:

"In the case of death or removal of the Secretary, the Executive Council shall appoint an Acting Secretary to serve until the next meeting of the House of Delegates, at which time the House shall elect an eligible member to fill the unexpired portion of the term of Secretary."

(c) Amend Chapter VIII, Section 1, by adding the following:

"Upon the death, resignation, or removal of a Vice-Councilor, or upon his succession to the office of Councilor, the Executive Council shall appoint an Acting Vice-Councilor to serve until the next meeting of the House of Delegates, at which time the House shall elect an eligible member to fill the unexpired portion of the term of the Vice-Councilor. If an acting Vice-Councilor succeeds to the office of Councilor he shall serve in like manner until the next meeting of the House of Delegates." Mr. Speaker, I move that these proposals be accepted to lay upon the table and be voted upon at the next meeting (2nd meeting—May 3, 1966) of the House of Delegates.

SPEAKER KOONCE: Is there a second to that motion?

(The motion was seconded.)

Do you understand it? It includes those three items. Any discussion? All those in favor let it be known by saying "aye"; opposed "no." So be it.

DR. SHAFFNER: Item 3: The Insurance Industry Liaison Committee has been an active working committee of the Society since 1959, but it has to date had no standing committee status, being appointed from year to year at the pleasure of the president. Because of the increasing importance of such a committee in representing the Society and its individual members to the various health insurance companies, it is recommended that it be given standing committee status in the By-Laws.

The following changes are therefore recommended:

(a) Amend Chapter X, Section 2, by inserting the following in the list of standing committees:

"A Committee on Insurance Industry," and further

(b) Amend Chapter X by adding a new section:

"Section 21: A Committee on Insurance Industry, appointed by the President, shall consist of a chairman and at least fifteen members representing as well as possible all geographic areas of the State and all subdivisions of medical practice. It shall be the purpose and duty of this committee, subject to the authority of the Executive Council and the House of Delegates, to represent and act for the Society in all matters affecting the relationship of the Society and its membership with all commercial health insurance companies. It may organize itself into as many subcommittees as necessary for its functions, and one of these shall be the Medical Section of the North Carolina Insurance Claims Review Service.

The actions of this committee shall not usurp the functions of other committees of the Society as herein provided, but upon request of any such committee and with approval of the president, this committee may assume such overlapping duties and functions as may involve the commercial health insurance companies. The committee shall present and promote to the health insurance industry the viewpoint of medicine on matters involving the two disciplines and shall effect a continuous liaison with the industry in matters relating the best interests of the public.

Mr. Speaker, I move this proposal be accepted to

lay upon the table and be voted upon at the next meeting (2nd meeting—May 3, 1966) of the House of Delegates.

SPEAKER KOONCE: Is there a second?

(The motion was seconded.)

DR. JOHN R. KERNODLE: Mr. Speaker, on behalf of our attorney, I would like to include two corrections to Section 21, starting on the third line following between "and" and "all," insert "as well as possible."

And on the 10th line, the end of the sentence that reads "The actions of this committee shall not usurp," change the word "usurp" to "assume."

DR. SHAFFNER: May I read these again and see if I have them correct?

"The Committee on Insurance Industry, appointed by the president, shall consist of a chairman and at least fifteen members representing as well as possible all geographic areas of the State and as well as possible all subdivisions of medical practice."

And the sentence "The actions of this committee shall not assume the functions of other committees of the Society. . . ."

SPEAKER KOONCE: Do you accept that?

DR. SHAFFNER: I accept it.

SPEAKER KOONCE: And the motion that it be approved as changed.

The seconder has a right not to second it if he doesn't want to.

(The seconder of the motion assented.)

SPEAKER KOONCE: Is there any discussion? All those in favor let it be known by saying "aye"; opposed "no." The "ayes" have it.

DR. SHAFFNER: There is an Item 4, a change of the By-Laws which was recommended or suggested by the Executive Council at its meeting yesterday, and you do not have a copy of this.

It seems that the name of the Committee on Grievances has a connotation which might leave something to be desired, and it was suggested that the Committee on Mediation would be a better name to describe the function of that committee, without the adverse connotation.

Therefore, it is recommended that we amend the By-Laws so that wherever a reference is made to "Committee on Grievances" it shall be changed to read "Mediation Committee."

DR. JOHNSON: To expedite this, yesterday I was at a meeting of the Executive Committee, and I also am, as of now, tomorrow, an immediate past Chairman of the Grievance Committee. This, along with other items of precedence, was presented to make more effective the carrying out of the duties of this committee, which I think is most important to our State Medical Society, and I move you, sir, that this recommendation be approved.

DR. SHAFFNER: The proposal will read as follows: Amend the By-Laws so that wherever a reference is made to Committee on Grievances, it shall be changed to read Mediation Committee.

SPEAKER KOONCE: Is there a second to this?

(The motion was seconded.)

SPEAKER KOONCE: Is there any discussion? All

those in favor let it be known by saying "aye"; opposed "no." The "ayes" have it.

DR. SHAFFNER: Your Constitution and By-Laws Committee has considered a recommendation that the continuous tenure of a member of any specific committee be limited to a specified number of years (for example, 6) so that the work of the Society may be shared by more members. While recognizing the merits of this proposal, your committee also sees that experienced, knowledgeable, and interested members might thereby be forced off a committee at a time they can and are willing to contribute much. A blanket limitation on tenure could be a detriment to good committee function. Except as specifically provided in the By-Laws, the president has the prerogative of appointing committee members each year, and it would appear to your committee that the president should have the opportunity to change or retain committee members as would best serve the Society. We, therefore, do not recommend any limitation on tenure at this time, but would encourage comments from delegates and the membership at large for future consideration.

Mr. Speaker, this completes the report of the Constitution and By-Laws Committee, and I thank you, sir.

SPEAKER KOONCE: Dr. Shaffner, do you make a motion that that report be approved with its few changes?

DR. SHAFFNER: I so move.

(The motion was seconded.)

SPEAKER KOONCE: This motion is to approve the report as a whole, with its slight changes. Any discussion? Those in favor let it be known by saying "aye"; opposed "no." So be it.

Next on our agenda is Item E, Report of Commissions, and I will ask Dr. Garrard if he will go through those and ask for any further reports.

(Vice Speaker Garrard assumed the Chair.)

VICE SPEAKER GARRARD: Administration Commission, Dr. Benton.

DR. WAYNE J. BENTON: No further report.

(A motion that the report be approved as printed in the Compilation was made, seconded, put to a vote and carried.)

VICE SPEAKER GARRARD: Advisory and Study Commission, Dr. Howard Wilson.

DR. HOWARD WILSON: No further report.

(A motion that the report be approved as printed in the Compilation was made, seconded, put to a vote and carried.)

VICE SPEAKER GARRARD: Annual Convention Commission, Dr. Paul F. Maness.

DR. PAUL F. MANESS: No further report, and I move its acceptance.

(The motion was seconded, put to a vote and carried.)

VICE SPEAKER GARRARD: Professional Service Commission, Dr. Mark Lindsey.

DR. MARK LINDSEY: No further report.

(A motion that the report be approved as printed in the Compilation was made, seconded, put to a vote and carried.)

VICE SPEAKER GARRARD: Public Relations Commission, Dr. David G. Welton.

DR. DAVID G. WELTON: I move the acceptance of the report as it appears in the Compilation, and we will have a subsequent report on Legislation by Dr. Beddingfield.

(The motion was seconded, put to a vote and carried.)

VICE SPEAKER GARRARD: Public Service Commission, Dr. Thomas G. Thurston.

DR. THOMAS G. THURSTON: No further report.

(A motion to accept the report as printed in the Compilation was made, seconded, put to a vote and carried.)

(Speaker Koonce resumed the Chair.)

SPEAKER KOONCE: The next report under F is a report from the Committee on Nominations to be read by President Paschal.

PRESIDENT PASCHAL: Mr. Speaker, Dr. John C. Burwell, of Greensboro, was Chairman of this Committee, and he transmitted to me under registered mail the following:

First would like to read to you for your information and it is self-explanatory, this letter directed to Dr. George W. Paschal, President of the Medical Society of North Carolina:

Dear Doctor:

In a separate envelope I am enclosing a list of the nominees put up by the Nominating Committee at its meeting in Greensboro, Sunday, April 27, 1966; though there was of course considerable discussion the candidates listed were each a unanimous choice by the committee present.

Due to the increasing inroads of the Federal Government in interfering with the practice of medicine, it was felt that some changes might prove advantageous to the Society. In particular, there was a strong feeling that the First Vice President would be more readily available for consultation and aid to the President, if he was selected from the same geographic area. After considerable discussion with our incoming President, this departure from previous custom was agreed upon, and selection was made accordingly.

I trust that in your reading of the nominations, you will make this explanation.

I submit that as information, Mr. Speaker.

I hold here the sealed envelope which came with this.

SPEAKER KOONCE: According to our Constitution and By-Laws, that is perfectly legitimate. The question of having one from the East and one from the West has been a custom, but it is not absolutely to be done.

PRESIDENT PASCHAL: I hold here a sealed envelope which contains the list of the nominees submitted by the Nominating Committee.

Their report is as follows: The Nominating Committee of the Medical Society of the State of North Carolina submits the following slate as nominees for the offices to be filled at the 1966 meeting of the Society:

President-elect—R. A. Ross, Chapel Hill

First Vice President—Dave Welton, Charlotte

Second Vice President—D. A. McLaurin, Garner

Speaker of the House—Donald B. Koonce, Wilmington

Vice Speaker of the House—Robert L. Garrard, Greensboro.

Two delegates to the AMA—Donald B. Koonce, Wilmington; John R. Kernodle, Burlington

Two alternates—D. E. Ward for Dr. Kernodle; Ted Raiford for Dr. Koonce.

Respectfully submitted, John Burwell, M.D., Chairman, Nominating Committee.

SPEAKER KOONCE: Are there any nominations from the floor?

(A motion was made that nominations be closed; the motion was seconded.)

SPEAKER KOONCE: It has been moved and seconded that the nominations be closed. Is there any discussion of this motion?

I will have to ask George to call for the vote, since I'm on their a couple of times, as is the Vice Speaker of the House.

PRESIDENT PASCHAL: All in favor of accepting the motion as was made, that the slate of officers as submitted be—rather that nominations be closed, let it be known by saying "aye"; opposed by a like sign. Carried.

Is there a motion that this slate of officers be elected at this time?

(A motion was made and seconded that the slate of officers as nominated be elected.)

PRESIDENT PASCHAL: Moved and seconded; is there discussion? If not, are you ready for the question? All those in favor let it be known by saying "aye"; opposed by like sign. The motion is carried without dissented.

The next is the nominations from the floor for the election of Trustees. First, Hospital Saving Association, Dr. Howell's term expires. Do I hear nominations from the floor?

DR. JOHN P. HARLOE (Mecklenburg County): It is my pleasure to place in nomination the name of Dr. Paul Deaton of Statesville.

He is an outstanding general practitioner in this area. He is aware of all the problems in many fields of medicine. His industry, his competence, intelligence and integrity is without peer.

I can therefore place his name in nomination without restriction and urge your support.

SPEAKER KOONCE: The nomination needs no second. Are there any other nominations from the floor? Do I hear a motion that nominations be closed?

(Such motion was made and seconded.)

Those in favor let it be known by saying "aye"; opposed "no." Dr. Deaton takes the term of Dr. Howell, whose term expires.

Now there is another term due to the death of Dr. Klostermyer. Is there a nomination from the floor?

DR. MURPHY: I would like to nominate Dr. F. A. Blount, Winston-Salem, North Carolina.

Dr. Blount is a pediatrician. Chairman of the Visit-Committee at the Medical School at Chapel Hill. In

addition, he is a part-time instructor at the Medical School in Winston-Salem.

SPEAKER KOONCE: Any further nominations from the floor?

(A motion was made that nominations be closed, which was duly seconded.)

SPEAKER KOONCE: Any discussion? Those in favor let it be known by saying "aye"; opposed "no." So be it.

Number 2, the Hospital Care Association, for the expiration of the term of Dr. Brewer.

DR. THOMAS E. FITZ (Catawba Co.): I would like to place in nomination the name of Dr. Joseph B. Stevens of Greensboro. Dr. Stevens is currently President of the North Carolina Society of Internal Medicine. He is quite active both in the practice and the administrative aspects of medicine, and I think he would be highly qualified, and I would like to nominate him without reservation.

SPEAKER KOONCE: Any further nominations?

DR. H. J. CARR, JR.: I would like to nominate Dr. J. S. Brewer for an additional term on the Hospital Care Association. His qualifications—he is a general practitioner of many years, past President of the Medical Society. His ability is unlimited. His experience is 15 years as a Trustee. His faithfulness and dedication is unquestioned. His intellect and judgment unlimited.

He has a genuine desire to serve the physicians of the North Carolina Medical Society. I nominate Dr. Brewer.

SPEAKER KOONCE: Any further nominations?

(A motion was made and seconded that nominations be closed.)

SPEAKER KOONCE: Discussion?

(Several seconding speeches were made.)

SPEAKER KOONCE: There is a motion before the floor to close nominations, and therefore no further nominations can be given until that motion is taken care of, but there can be discussion.

(The question was called.)

Those in favor of closing the nominations let it be known by saying "aye"; those opposed "no." The "ayes" have it, and the nominations are closed, and the names of Dr. Stevens and Dr. Brewer are before us. According to our By-Laws, where there is more than one candidate for a position, it has to be held by written ballot.

I would like to appoint Dr. George Johnson, Dr. Bill Romm, Dr. Willard Goley, Dr. John Harloe, and Dr. Lynwood Williams as Chairman of the Tellers.

Medical Care Commission, Dr. Johnson's term expires. Do I hear any nominations?

DR. STREET BREWER: I would like to renominate Dr. Harry L. Johnson, Sr.

SPEAKER KOONCE: Are there any other nominations

(A motion was made and seconded that nominations be closed.)

SPEAKER KOONCE: Any discussion of the motion? Anybody want to give a speech for him?

A DELEGATE: How long is the term of office?

SPEAKER KOONCE: Four years. There has been a motion that nominations be closed, and it has been seconded. Those in favor let it be known by saying "aye"; opposed "no." So be it.

Next, is there a motion to elect?

(Such motion was made and seconded, put to a vote and carried.)

No. 4 is the Retirement Saving Plan Committee, two openings to take the place of Dr. Paul W. Johnson of Winston-Salem, and Dr. Jesse Caldwell.

Do I hear any nominations from the floor to fill these terms?

DR. KERNODLE: Mr. Chairman, I would like to nominate the two men to follow themselves as members of the Retirement Saving Plan Committee.

SPEAKER KOONCE: You make that in the form of a motion?

DR. KERNODLE: Yes.

(The motion was seconded.)

SPEAKER KOONCE: Any discussion? The motion has been made that they be elected to succeed themselves, so we don't need to close nominations.

VICE SPEAKER GARRARD: Next we come to the report of the Mediation Committee. You will find that in the Compilation reports. Do you have any additional report on grievances to make at this time.

DR. AMOS JOHNSON: No; there are no additional reports. That was taken care of as a sub-head of the recommendation that we alter the name.

VICE SPEAKER GARRARD: The Committee on Negotiations, Item H.

SPEAKER KOONCE: I was going to stop here and have our caucus, since we're waiting for the votes to be counted.

I am now going to call on Dr. Beddingfield to give a supplementary report on Legislation. (Dr. Beddingfield gave a report.)

(See report in report of Executive Council, April 30, 1966.)

SPEAKER KOONCE: I think that should be received as information. You don't require action?

DR. BEDDINGFIELD: No.

DR. SHAFFNER: A point of order Mr. Speaker. It was brought to our attention that Dr. Paul Johnson, who was elected a member of the Retirement Saving Plan Committee, is no longer a member of the State Society, and therefore ineligible for election to this office.

SPEAKER KOONCE: Thank you; that has been called to my attention, and we will reopen the nominations for that in just a second.

I would like to announce between Dr. Stevens and Dr. Brewer for Hospital Care Association: Dr. Brewer, 83; Dr. Stevens, 54, and Dr. Brewer is reelected.

Now Dr. Caldwell has been elected to succeed himself. Dr. Johnson was elected, but no longer is a member of the State Medical Society and is not eligible. Therefore, the floor is open for nominations to take the expired term of Dr. Paul Johnson.

Do I hear a nomination from the floor for the Retirement Saving Plan Committee?

DR. HUBERT POTEAT: Mr. Speaker, I place in nomination Dr. John Robert Kernodle.

SPEAKER KOONCE: Dr. Kernodle has been placed in nomination. Do I hear further nominations from the floor?

(A motion to close nominations was made and seconded.)

Any discussion? All those in favor let it be known by saying "aye"; opposed "no." Do I hear a motion to elect Dr. Kernodle?

(Such motion was made, seconded, put to a vote and carried.)

SPEAKER KOONCE: It has just been called to my attention—one of many mistakes today—that we closed the nominations on Dr. Blount and Dr. Deaton, but we did not call for an election. I would ask for a motion that those two be elected.

(Such a motion was made, seconded, put to a vote and carried.)

Now, with your permission, it would be a good idea if we went on to the organization of the Nominating Committee and held the caucuses of the districts.

Please remember that no man can succeed himself. There has been some confusion in the past. In order to clarify, the members of the Nominating Committee from the 4th, the 7th, 8th and 9th Districts, are not eligible for reelection.

(Recess for caucus.)

SPEAKER KOONCE: I would like to read these to you as soon as I can.

The results of the Nominating Committee:

First District, to succeed himself, Dr. John Payne.

Second District, Ernest Furgurson.

Third District, Dr. John Nance.

Fourth District, Dr. John McCain.

Fifth District, Dr. Floyd Knight.

Sixth District, Dr. J. Kempton Jones.

Seventh District, Dr. John R. Ashe.

Eighth District, Dr. Jack Lynch.

Ninth District, Dr. Henry Cutchin.

Tenth District, Dr. John R. Hoskins, to succeed himself.

Now we would like you to meet as soon as possible, immediately, behind the curtain.

The next item is the report of the Executive Council, submission of budget for adoption, and presentation of it for adoption, by our President, Dr. Paschal.

PRESIDENT PASCHAL: In addition to the minutes of the Executive Council meetings, which you have in your folder, there is additional information to be submitted to you on the action of the Council yesterday.

The first of these has to do with the Headquarters Facility Committee. The Committee recommended that the Society acquire a tract of land which is now known as the Mordecai Property located on Wake Forest Road in Raleigh. An option for the sale of the property for \$100,000 was delivered to Mr. Anderson to be open until November 1, 1966. The Committee recommended the purchase of the property; a motion made by Dr. Bridger, seconded by Dr. Raiford, was put to a vote and carried.

Mr. Speaker, I make a motion that this recommendation be approved by the House of Delegates.

SPEAKER KOONCE: You have heard the recom-

mendation. The motion has been made by the President. Do you hear a second to the motion?

(The motion was seconded.)

Discussion? Is the motion understood? No discussion? Those in favor let it be known by saying "aye"; opposed "no." The "ayes" have it.

PRESIDENT PASCHAL: Now then, one additional thing from the Executive Council. It has to do with a motion from Durham-Orange County which was submitted late from Dr. Jack Hughes, the Chairman of the Committee on Legislation of Durham-Orange County Medical Society:

"That the House of Delegates request the President of the State Medical Society to direct an appropriate committee to make an indepth study of the activities of the State Medical Society with regard to utilization of physician time and effort and Society monies. This committee to report at the Society's next annual meeting making recommendations for revision or elimination, where possible, of those activities which do not constitute an efficient and/or worthwhile utilization of members' time and effort and Society's monies."

A motion approving this resolution was made by Dr. Raper, seconded by Dr. Murphy, and passed.

Mr. Speaker, I move the approval of this recommendation.

(The motion was seconded by Dr. Welton.)

SPEAKER KOONCE: Is there any discussion of this recommendation?

DR. JACK HUGHES: A number of members of this Society, many of whom are present, have pointed out in the past that an enormous amount of physician time and energy, as well as out-of-pocket cash, is expended in the activities of the State Society, and at least in some of these areas it appears—and I repeat, appears—that the results achieved are perhaps not worth the cost in time and energy.

The Durham-Orange County Medical Society studied this matter in some depth and felt that there was reason to study the matter further. And so it has asked the Society to take this action.

Now the Durham-Orange Society is very anxious that this action not be construed as criticism of any members of the Medical Society, or its officers, or Executive Headquarters, or anyone else, but rather as an effort to determine if there are changes that could be made to make for a more efficient and effective organization. Thank you.

SPEAKER KOONCE: The Council understood that and discussed it in detail.

Any further discussion of this motion?

(The question was called.)

All those in favor let it be known by saying "aye"; opposed "no." So be it.

PRESIDENT PASCHAL: Mr. Speaker, at this time, I ask for the approval of the minutes as submitted in the Compilation, and also for the insert which has to do with the November 21st meeting of 1965.

Mr. Speaker, I move that they be approved by the House of Delegates.

SPEAKER KOONCE: You have heard the motion. Do I hear a second?

(The motion was seconded.)

Any discussion? Those in favor let it be known by saying "aye"; opposed "no." The "ayes" have it.

PRESIDENT PASCHAL: Finally, Mr. Speaker, I speak to the adoption of the budget which was adopted by the Executive Council at the September 26, 1965 meeting, and I submit this at this time and move that it be approved.

SPEAKER KOONCE: Do I hear a second to this motion?

(The motion was seconded.)

SPEAKER KOONCE: It has been moved and seconded and you all have this in hand; is there any discussion or question?

DR. BOYETTE (Duplin): Item 17, Rural Health, Consultants' Salary, and Rural Health Consultant's Travel Expenses. I believe that should be the educational consultant, because this lady serves for several committees and not merely Rural Health.

In view of the fact that we're going to go into what committees do and so on, we would not like to think that all this money is being spent just for the Rural Health Committee.

PRESIDENT PASCHAL: The Committee is aware of this. However, this was so inserted for purposes of simplification of the budget. It recognizes that there is some overlapping in other areas. But it was thought that this would be the most reasonable place to make this insertion.

SPEAKER KOONCE: That I think is similar to over a period of years the way the Public Relations budget has been put together, because it's much more simplified. Nobody is going to get blamed for too much, I don't think.

Any further discussion? Is that explanation satisfactory to you?

DR. BOYETTE: I just wanted to make it clear.

SPEAKER KOONCE: The House of Delegates understands it and I know the Council does. All those in favor let it be known by saying "aye"; opposed "no." The "ayes" have it.

PRESIDENT PASCHAL: Mr. Speaker, that completes my report.

SPEAKER KOONCE: Next is Item J, Consideration of nominations—Dr. Paschal.

PRESIDENT PASCHAL: Mr. Speaker, members of the House: This is submitted to you for information.

Sometime ago the President of the Society was given the approval of the Council to write letters to the Board of Trustees of the American Medical Association nominating a representative from our Society to the Council on Legislation. This was done, and Dr. Edgar Beddingfield's name was submitted.

We are aware of his capacity in this field. We feel that he can make a significant contribution to the Council on Legislation of the American Medical Association. We think it affords us an opportunity to have additional representation on the higher level.

While this is submitted to you for information, I think it would add strength to his nomination, which has already been written, if he received endorsement from this House of Delegates.

I move that this action taken by the President be endorsed by the House of Delegates.

DR. SAMS: I take great pleasure in seconding that motion. Dr. Ed Beddingfield is a very wonderful guy.

SPEAKER KOONCE: Thank you, Dr. Sams. The President asks that the transcription of that also be sent to the Board of Trustees of the AMA.

PRESIDENT PASCHAL: Yes, I include that and accept it.

SPEAKER KOONCE: Do you accept that, Dr. Sams?

DR. SAMS: Yes.

SPEAKER KOONCE: The motion has been made and seconded. Any discussion? Those in favor let it be known by saying "aye"; opposed "no." The "ayes" have it.

PRESIDENT PASCHAL: Mr. Speaker, similarly, a letter was written to the Board of Trustees regarding a nominee for the Council on Medical Service of the AMA, and for this place we submitted the name of Dr. John Robert Kernodle, recognizing again his eminent qualification for participation on this Council.

I move the endorsement by the House of Delegates of the action previously taken, and that this be forwarded as well to the AMA.

(The motion was seconded by Dr. Amos Johnson.)

SPEAKER KOONCE: Any discussion? That has been moved and seconded. If not, all those in favor let it be known by saying "aye"; opposed "no." The "ayes" have it.

Item K has been taken care of.

Item L, reports of all committees, which was in your Compilation. Is there any discussion, or do I hear a motion that they be approved with the additions that have been made?

(Such motion was made by Dr. Brewer and seconded by many.)

Any discussion? Those in favor let it be known by saying "aye"; opposed "no." The "ayes" have it.

According to our agenda, we are supposed to recess now. We have two other items which we can include very easily, with your permission.

Under new business, item (a), for Honorary Membership, Dr. V. Birch Rambo. As you know, according to our Constitution, an honorary member has to be passed by two-thirds of the voting members of the House of Delegates present at the time.

Mr. Barnes, will you explain this please?

MR. BARNES: Dr. Rambo was nominated by the Avery County Medical Society for his recognition as an honorary member, and have his biographical data.

SPEAKER KOONCE: As you know, under classification of membership, an honorary member can be elected by two-thirds of the House of Delegates, which gives him the right to participate in all functions of the Medical Society without the payment of dues, except the right to vote and hold office.

Do I hear a motion that he be elected to honorary membership?

(Such motion was made and seconded.)

Is there any discussion? It calls for a two-thirds vote.

Will those in favor please rise? I declare it two-thirds.

We have one other item under item M, and I will ask Mr. Barnes to explain that to you.

MR. BARNES: This is simply to report the condition of the Committee on Arrangements which the Executive Council had authorized, that we have finalized a date for the 1967 Annual Meeting of the State Medical Society in Pinehurst, with the Carolina Hotel as headquarters, the dates being May 20 to 24, 1967.

The headquarters has also arranged a reservation at Pinehurst for 1968; that is pending action of the Committee on Arrangements as assigned it by the Executive Council last fall, and will be decided at the Conclave of Committee Meetings in the Fall of 1966 as to 1968 place of meeting.

SPEAKER KOONCE: That is presented to you as information. Is there any other business to come before this House?

DR. SHAFFNER: I would like to put in nomination for honorary membership Dr. Annie V. Scott of High Point, North Carolina.

It is my understanding that Dr. Scott has had an interest in maintaining her membership in the State Society, but because she has not been a continuous member for twenty years, she is not eligible for life membership. But according to her activities, I think she is certainly eligible for honorary membership by virtue of her previous activities.

She was born in Guilford County, June 28, 1889. She graduated from Woman's College, University of U.N.C., Greensboro, 1914, and Woman's Medical College of Pennsylvania in 1918.

She has been the recipient of many honors, and has held numerous academic positions while serving in North China, Peking, at the Cheeloo University Medical College and Hospital from 1920 through to 1939. She has been associated with the Lying-In Hospital and Bellevue Hospital in New York City, and many other institutions of like nature.

She is now retired and living in Guilford County, and with this long service overseas, and recognition and citations for her work, since she has returned and over there, on behalf of the Council I put her name in nomination for honorary membership.

SPEAKER KOONCE: Do I hear a motion that this nomination be approved?

(Such motion was made and seconded.)

Any discussion? Those in favor please stand.

I declare two-thirds.

Any further business to come before the House of Delegates.

I thank you, and if there is a motion to adjourn, we will adjourn until the second session Tuesday afternoon, 2:30, in the same place.

(The meeting adjourned at 5:15 p.m.)

TUESDAY AFTERNOON SESSION

May 3, 1966

The Second Meeting of the House of Delegates convened at 2:35 o'clock, Dr. Donald B. Koonce presiding as Speaker.

PRESIDENT PASCHAL: I now call to order the Second Meeting of the House of Delegates of the Medical Society of the State of North Carolina, and I turn the podium over to our Speaker, Dr. Donald Koonce.

SPEAKER KOONCE: Ladies and gentlemen, I hope this meeting will be comparatively short, but not too short.

The first thing on our agenda, unfinished business, is final ratification of the By-Laws, second reading of any amendment introduced at the first meeting on May 1. Dr. Louis Shaffner.

DR. SHAFFNER: Mr. Speaker and Members: Before I reread the By-Law changes and recommendations, might I add an additional report from the Committee which was intimated last time but not made specific.

If you will remember, at the meeting on Sunday, we read a recommendation in Item 2, a change in the Constitution, in which the voting for the members of the Board of Medical Examiners would be on the last meeting of the General Sessions of the Annual Meeting, rather than the second; that is to put it in conformity with general practice of the last several meetings.

We would like also to recommend as Item 3 a change in the Constitution, a similar type of change which would let the election of the members to the Editorial Board of the Medical Journal also be at the last meeting of the General Sessions and not specifically called the Second Meeting.

Therefore, we would recommend a change to amend Article IX, Section 3 of the Constitution by changing the word "second" in the first sentence to the word "last," so that the first sentence will then read: "The seven elected members of the Editorial Board of North Carolina Medical Journal shall be elected at the last General Session of the Annual Meeting," and so on, to the end.

Mr. Speaker, I move the acceptance of this recommended change in the Constitution to lay upon the table for a year and to be voted upon at the next meeting next year.

(The motion was seconded.)

SPEAKER KOONCE: Any discussion of this? This is a simple procedure, and it is perfectly legitimate to bring it up at this time, and it will be ratified at our next meeting. It cannot be ratified until next May.

Is there any question of this? If not—I'm going to ask for a two-thirds vote, although it isn't necessary. Those in favor let it be known by rising. I declare that a two-thirds vote is taken, and therefore it will be brought up next year for ratification along with the change of the day of election of the Board of Medical Examiners.

DR. SHAFFNER: At the meeting on Sunday, we lay upon the table several changes in the By-Laws which, if you have your same copy from Sunday, you may follow along and remind yourself of, if you wish.

Item 1, a proposed change to change the name from Assistant Executive Secretary to Assistant Executive Director, and this change would be to amend Chapter VI, Section 5 of the By-Laws.

Mr. Speaker, I move that this change in the By-Laws be adopted.

(The motion was seconded.)

SPEAKER KOONCE: It has been seconded. Any discussion? If not, those in favor let it be known by saying "aye"; those opposed "no." So be it.

DR. SHAFFNER: Item 2 of the proposed changes in the By-Laws as presented last time consists of three amendments to the By-Laws, the purpose of which is to make provision so that the Executive Council can fill any vacancies in the office of Vice Councilor or Secretary, should such vacancies occur during the three-year period, tenure of any of these particular offices.

(Dr. Shaffner then read the proposed section.)

DR. SHAFFNER: Mr. Speaker, I move that these three proposed changes in the By-Laws be adopted.

(The motion was seconded.)

SPEAKER KOONCE: I hear that it has been seconded. Gentlemen, you understand this. This is a simple thing which we had not anticipated before, where there would be a Vice-Councilor who would step up to the Councilor's place, or a Vice-Councilor in this one instance to step up to the Vice Presidency, and there was a vacancy in the Vice-Councilor office, and in our Constitution and By-Laws there was no arrangement whereby that Vice-Councilor could be replaced.

Do you understand? Any discussion of it? It has been moved and seconded. Any discussion at all? If not, let those in favor say "aye"; this is a change in the By-Laws and does not need a two-thirds vote. All those in favor say "aye"; opposed "no." So be it.

DR. SHAFFNER: Item 3, Change in the By-Laws. This has to do with giving standing committee status to the Insurance Committee. (Dr. Shaffner then read the proposed section.)

DR. SHAFFNER: Mr. Speaker, I move this change in the By-Laws.

SPEAKER KOONCE: Is there a second to this motion?

(The motion was seconded.)

SPEAKER KOONCE: The motion has been seconded. Is there any discussion? Is it understood? Those in favor let it be known by saying "aye"; opposed "no." So be it.

DR. SHAFFNER: The final recommended change which is not on your printed list, but which was presented last Sunday, was the suggested change in the name of the Committee on Grievances to the Mediation Committee.

It is recommended, therefore, to amend the By-Laws so that wherever a reference is made to Committee on Grievances, it shall be changed to read "Mediation Committee."

Mr. Speaker, I move the adoption of this change in the By-Laws.

(The motion was seconded.)

SPEAKER KOONCE: Any discussion? All those in favor let it be known by saying "aye"; opposed "no." So be it.

That's the end of Dr. Shaffner's report.

Thank you, Louis, for your usual job very, very well done.

The next item under unfinished business is Item (b),

Report of Committee to Review the two messages of the President, Dr. Charles Styron.

DR. STYRON: Mr. Speaker, the Committee on the President's two messages has heard and reviewed these messages.

The first is a succinct, inclusive and accurate resume of the Society's activities in the past year. The message is demonstrative of the energetic administration of our President, his complete grasp of the many facets of the Society's activities, and his ability to deliver to us a concise summary of the long, active and difficult year.

The second message of the President is a summation of the changes that have occurred in medicine, his assessment of our future, and a call to our membership to actively pursue optimistically our responsibilities in the coming year.

Mr. Speaker, the Committee recommends to you, sir, and to the House of Delegates, to accept these two messages of George W. Paschal without revision, and recommends that these messages be recorded in the archives of the Society for future reference.

Theodore Raiford, Hubert Poteat, and Charles Styron, Chairman.

SPEAKER KOONCE: The reason for the change in those two members was that the two members other than Dr. Styron who were appointed on Monday could not be present, and the Speaker took the privilege of appointing two other members. I hope you understand that.

Do you make that as a motion, sir?

(Such a motion was made.)

The motion is made as a member of the House of Delegates, and he has a perfect right to make it. Is there a second to the motion?

(The motion was seconded.)

SPEAKER KOONCE: The motion has been made and seconded. Any discussion? If not, those in favor let it be known by saying "aye"; opposed "no." So be it.

The next item (c), which is a report of the Resolutions Committee No. 1, Dr. Mark Lindsey. With Dr. Lindsey's permission, if you don't mind, I have not had a chance to review their report, but it looks as though there are several items there, and I'm going to request him, if you don't mind, that we take them up one by one.

DR. MARK LINDSEY: Mr. Speaker, at the outset, the Committee wishes to commend those various proposers of their resolutions. As you know, an open hearing was held yesterday, and about an hour and a half of discussion was undertaken. This Committee met this morning, and we found there was much overlapping and duplication, and tried in so far as possible to combine many of these resolutions.

First, if you will turn to Resolution No. 12, North Carolina Medical Foundation, I will read the preamble.

The Executive Council has authorized the incorporation of the North Carolina Medical Foundation, Inc., devoted exclusively to educational, scientific and charitable purposes which are exempt from taxation under the U. S. Internal Revenue Code.

The corporation has been organized and its Charter

and By-Laws have been submitted to the District Director of Internal Revenue for determining that it meets the requirements of the statutory exemption, particularly for the acceptance of contributions and bequests which are tax deductible. The membership of the Foundation will consist of the voting members of the Executive Council of the Society, which will elect the Directors of the Foundation, who will in turn elect its officers. It will be possible for the Foundation to construct a building, borrow money for such construction, and to lease part of it to the Society for use by its headquarters staff and to use the other portions of the building for its educational and scientific purposes. The House of Delegates will be asked to approve the implementation of the Foundation and to consider the advisability of transferring some property or funds of the Society to the Foundation for the construction of a building and for use in its activities.

RESOLVED, That the formation and activation of the North Carolina Medical Foundation, Inc., as now constituted, and the change of the name of such corporation to another appropriate name its Directors may choose is authorized and approved.

That the Treasurer of the Society is authorized and directed to transfer and give it to the North Carolina Medical Foundation, Inc., securities or funds in the amount of \$105,000 subject to the approval of the Finance Committee of the Society. Mr. Speaker, I move the adoption of this resolution.

SPEAKER KOONCE: This motion is perfectly in order. Do I hear a second to the motion?

(The motion was seconded.)

SPEAKER KOONCE: The motion has been seconded. Is there any discussion?

DR. JOHN HAMRICK (Cleveland Co.): I don't understand this resolution. This is something that has come up fairly quickly, and I don't think the members of the Society at large have had enough opportunity to know exactly what it means. It may be a really good thing, and it may be exactly what we need.

Our County Society, in asking that the delegates not be in favor of this resolution unless we have a little more information about it—the feeling at home is that it has been brought up a little too quickly, that we should have known a little something beforehand, so that we could have had a little time to understand it.

Have we got \$105,000 in past dues to turn over to somebody? Our dues are pretty high as they are.

SPEAKER KOONCE: Who are you directing your question to, and what specifically do you want to ask?

DR. HAMRICK: Whoever can answer them. The one question I asked was about this money that we have there to turn over. Where do we accumulate that, and how, and why should we turn this over? And what is the real purpose of this thing?

SPEAKER KOONCE: You have one specific question. Where do these monies arise from.

Dr. Benton, would like to answer that?

DR. BENTON: I would like to have been forewarned about this, and I could have more specific information. The \$105,000 represents an accumulation of

funds that has accumulated over the last 30 years, and have been invested in mutual funds.

The reason these things came up and haven't cut the dues back—this organization, like any other business, cannot have a budget and make it come out exactly even on the dollar. It's going to be a little bit left over, or a little overspent, and through the years that little bit that was left over, at the end of the year, has been invested in mutual funds, and it has gradually accumulated so that now we have some \$106,000. Does that answer that part?

SPEAKER KOONCE: That's purely and simply an investors' mutual that you have. You're not talking about a piece of property.

DR. BENTON: No, sir.

SPEAKER KOONCE: Any other questions, John?

DR. HAMRICK: The other question in my mind is, what is the benefit of this, and how is it going to help us? Is this the best way we can spend this money?

SPEAKER KOONCE: Dr. Benton, would you like to answer that?

DR. BENTON: I'm not the policy-making man. I believe it would be improper for me to say. I can tell you where the funds are and where it's coming from.

SPEAKER KOONCE: I'd like for John's information to state that this resolution went out to the members of the House of Delegates on March 3rd, and this I understand is in May. And if there had been protests, they could have very adequately been written to the Executive Committee, and the Executive Committee has studied this very carefully, and that was their opinion.

The point I'm trying to make is not to influence your vote, but to state that you have been adequately circularized of this, and if you are not aware of it, it isn't the fault of the Executive Council.

John, do you want to say anything else?

DR. HAMRICK: Just one more thing. It was not received in our County until after the first of April. We got this material about two days before our April meeting of the County Medical Society, and it was the general feeling that we should have been circularized sooner on it, and I still have that feeling.

I do not believe it has been adequately circularized. I think it should have come up several months ago, so that we could have had a little open discussion on it.

Is there any further discussion of this matter?

DR. ELIAS FAISON: It's subject to the approval of the Finance Committee of the Society. I happen to be one man on the Finance Committee, and there are only three of us.

Suppose two men said they didn't approve this. Couldn't you delete these words so that we're acting upon it, the House of Delegates, as a matter of fact instructed by you to approve it.

SPEAKER KOONCE: In other words, your request to this committee is that you delete what words now?

DR. FAISON: Subject to the approval of the Finance Committee."

SPEAKER KOONCE: I would have to ask the Committee's permission to do that, because the resolution was submitted to you for action.

It has been moved and seconded that the resolution

be approved, and this could not be done without the approval of the committee. In your committee here? Will you ask your committee if they will accept that change?

DR. JOHN MCCAIN: Would it be acceptable for it to be changed "as arranged by the Finance Committee?"

SPEAKER KOONCE: Would you ask your committee? (A pause).

It's approved by the committee that the change be made. Therefore, it's perfectly legitimate.

Now the motion has still been made by Dr. Lindsey. Would the seconder like to withdraw his second or will he still stand on the second? Do I hear the seconder?

DR. BEDDINGFIELD: I'll second it.

DR. BENTON: Point of order. The Constitution and By-Laws says that the Finance Committee will invest all funds. I ask you would that be contrary?

SPEAKER KOONCE: I don't think so.

DR. BENTON: It specifies that the funds shall be invested by the Executive Secretary on advice of the Finance Committee, and this is investing in another organization.

SPEAKER KOONCE: I don't think that would have anything to do with it, Dr. Benton.

Any further discussion? If not, all those in favor let it be known by saying "aye"; opposed "no." So be it.

DR. LINDSEY: Your Reference Committee finds that many of the resolutions, especially numbers 1, 2, 3, 4, 9, 10, 13 and 14 are largely similar in intent and philosophy and might be rewritten as two substitute resolutions, embodying the principle features of the several resolutions.

The subject of the first committee substitute resolution is the clarification of policy regarding professional fees under State Plans for Medical Assistance.

The second substitute resolution endeavors to combine other philosophy from resolutions numbers 1, 2, 3, 4, 9, 10, 13 and 14 and relates to compensation of physicians under any tax supported government program.

It is the sense of the committee that the purposes of the first resolution are as follows:

(1) to state the policy of the Society both for the benefit of our members and for government in regard to physicians accepting fees for professional services under State Plans for Medical Assistance, and

(2) to adopt the position that such services should be compensated for at the level of usual and customary fees as are charged private patients where third-party sponsorship is not involved.

Your Committee therefore offered the following committee substitute resolution:

In 1961, the Medical Society of the State of North Carolina established a policy where-in the physicians of the Society at that time would not seek (and by implication would not accept) vendor payments from government services rendered under the Kerr-Mills Act. However, recent Federal legislation (PL 89-97 Title XIX, Section 1902 (a)) relating to State Medical Assistance programs makes it necessary that North Carolina, among other things, pay physicians for services rendered to persons eligible under State Plans for Medical Assistance by 1970, or forego all matching federal funds for such programs. It is anticipated that the

government of our State might find it advantageous for the state to begin participation in the new federal program prior to 1970, possibly in 1967. Thus, the physicians of the Medical Society of the State of North Carolina find it necessary to re-evaluate the action taken in 1961 in order that they might thereby cooperate with the anticipated State implementation of the new Federal legislation.

The House of Delegates of the American Medical Association in June 1965 passed the following resolution:

"It is recommended that when the government assumes financial responsibility for an individual's health care, reimbursement for professional services should be on the same basis as in the case of other indispensable elements of health care. Therefore, reimbursement for the services of physicians participating in government-supported programs should be on the basis of usual and customary fees."

THEREFORE BE IT RESOLVED, That the Medical Society of the State of North Carolina does adopt the policy that when any branch of government assumes any financial responsibility for an individual's health care, reimbursement for professional services should be on the same basis as other indispensable elements of health care; therefore, reimbursement for the services of physicians rendering services to persons eligible under government supported programs should be on the basis of usual and customary fees; and be it further

RESOLVED, That this statement of general policy be also specifically applied in connection with the North Carolina implementation of Title XIX of Public Law 89-97 in whatsoever fashion such may be done; and be it further

RESOLVED, That the acceptance of such compensation by physicians for services rendered under State Medical Assistance programs is approved.

Mr. Speaker, I move the adoption of this resolution.

SPEAKER KOONCE: Do I hear a second to the motion?

(The motion was seconded.)

Do you all understand it? Is there any question? Any discussion?

(After considerable discussion the motion carried.)

DR. LINDSEY: Substitute Resolution No. 2.

Congress has enacted PL 89-97 which endeavors to supply a fiscal mechanism through which a large measure of the health care needs of the aged are met, irrespective of need, and in addition prescribes a mechanism for providing payment of physicians' fees for services rendered to the indigent and medically indigent.

The Medical Society and other members of the medical profession have been willing to donate their services to the indigent and medically indigent but under the new Federal legislation this is no longer possible.

Other agencies, governmental and nongovernmental, have sponsored medical programs with which the medical profession has cooperated and at less than normal charge, or without charge.

Moreover, the Medical Society has sponsored "service type" insurance contracts, making available health insurance at reasonable rates to certain income groups,

and in which the physicians' participating in such service programs agreed to accept as total payment a reduced fee. Therefore, fee schedules published by such service plans do not represent usual charges and should not be used in determining customary fees.

It is recognized that with the rapid implementation of a multitude of new Federal programs which may be applied widely but not uniformly throughout the state (such as health care available under programs of the Appalachia Act, Office of Economic Opportunity, U. S. Department of Education, and others) county medical societies are being asked to approve agreements relating to fees for physicians' services in their community. It is believed that this Society can offer useful advice to the county societies in such matters, and offers its facilities and experience to guide the counties in their deliberations on such matters.

THEREFORE LET IT BE RESOLVED, It is declared to be the policy of Medical Society of the State of North Carolina that all members of the medical profession should be paid their customary and reasonable fees for all services they may render under any program sponsored by the Federal, State and county governments, and that no existing fee schedules be utilized in determining usual and customary fees for physicians' services; and it is further

RESOLVED, That all county medical societies are urged to seek the counsel of the State Medical Society prior to entering into any local contracts or agreements having reference to professional charges with any third party sponsorship; and it is further

RESOLVED, That the Executive Council of the Medical Society of the State of North Carolina be empowered as it may deem necessary or advisable to suspend, discontinue, or modify, any or all contracts or agreements relating to compensation for professional services, which now exist with governmental or nongovernmental agencies or parties.

Mr. Speaker, I move the adoption of this resolution.

(The motion was seconded.)

(After considerable discussion the motion passed.)

SPEAKER KOONCE: That, as I understand it, is the complete report of Reference Committee No. 1.

Now we will call for the report of Reference Committee No. 2, Dr. Howard Wilson.

DR. WILSON: Mr. Speaker, Reference Committee No. 2 wishes to make the following report on resolution numbers 5, 6, 7, 8 and 11.

Relative to Resolutions 5 and 6, Reference Committee No. 2 recommends that statewide billing of annual dues be continued for AMA, State, District, and County Societies (when the county options for collecting of its dues) be listed. N. C. Medpac and Ampac contributions are to be listed below, eliminating the small print and identifying the latter item in large print as "Voluntary and non-tax deductible."

I move the adoption of this resolution.

SPEAKER KOONCE: The Chairman of this Committee is a member of the House of Delegates and has a perfect right to make a motion. Is there a second?

(The motion was seconded.)

Any discussion? All those in favor let it be known by saying "aye"; opposed "no." So be it.

DR. WILSON: As to Resolution No. 7—Reference Committee No. 2 considered Resolution No. 7 and recommends that the Medical Society of the State of North Carolina go on record as making known to its members its disapproval of any contract or other arrangement whereby a radiologist merges his professional service charges and recommends separate billing of hospital and professional fees.

I move the adoption of this recommendation.

SPEAKER KOONCE: Do I hear a second?

(The motion was seconded.)

SPEAKER KOONCE: It has been seconded by several. Any discussion? Those in favor let it be known by saying "aye"; opposed "no." So be it.

DR. WILSON: Relative to Resolutions 8 and 11—Your Reference Committee No. 2 recommends that resolutions 8 and 11 be combined into one resolution and further recommends that the Medical Society endorse the present health information provided on the new North Carolina Driver's license form; and finally recommends that our delegates to the AMA House of Delegates introduce a resolution at AMA House of Delegates Meeting in June 1966 that this health information be recommended for extension to other state driver license systems.

I move the adoption of this recommendation.

SPEAKER KOONCE: Do I hear a second?

(The motion was seconded.)

Any discussion? All those in favor let it be known by saying "aye"; opposed "no." So be it.

DR. WILSON: Mr. Speaker, I move the adoption of this report as a whole.

SPEAKER KOONCE: This is not absolutely necessary, but it works out a little bit better. Any second to that?

(The motion was seconded.)

Those in favor let it be known by saying "aye"; opposed "no." So be it.

DR. WILSON: Mr. Speaker, I wish to thank my committee, consisting of Hubert M. Poteat and W. Otis Duck, and to thank all the members of the State Society who appeared before our Reference Committee. Thank you.

SPEAKER KOONCE: For the clarification of our records, I'm sure I assigned this to a reference committee, but the resolution with regard to Dr. Lenox Baker is not being reported, and do I hear a motion that it be approved?

(Such a motion was made and seconded.)

Any question? Those in favor let it be known by saying "aye"; opposed "no."

PRESIDENT PASCHAL: Mr. Speaker, it has been suggested that I bring you a communication from Mr. Leo Brown, the assistant to the Executive Vice President of the American Medical Association, which I think would be of interest to you, and to our members of the House of Delegates. Mr. Brown writes: This is directed to Dr. M. D. Hill from Raleigh, and he writes:

Dr. Blasingame has asked me to handle your request

for information on the changes in the House of Delegates Committee structure which were adopted by the AMA House of Delegates in Philadelphia as an outgrowth of the recommendations of the Gundersen Committee. Attached is a copy of the Reference Committee report which deals with this subject, along with a copy of the report to assist you in the review of the overall recommendation.

The only major change was in the Reference Committee of the House of Delegates. Instead of having 15 reference committees, this has been changed to call for three committees by name: Rules and Order of Business, Credentials, and Amendments to Constitution and By-Laws. All other committees will be by letter only, and an adequate number will be appointed to equalize the workload as much as possible in each of these committees.

As in the past, every effort will be made to group the resolutions and reports in such a manner as to refer them by subject to one committee.

This is submitted for your information.

SPEAKER KOONCE: There is no action necessary on that. One other thing in the House of Delegates is the question of apportionment of delegates because the House of Delegates there is getting a little bit too large and it will be changed a little bit, but not remarkably, and this is just information.

Is there any new business? Is there any old business?

Could I make just one remark before we close?

I think you have found in this afternoon's discussion that our reference committees which we have had for a good many years are invaluable. Open hearings which had not been held too often, once or twice, and were not too well organized—maybe we were a little lax, and I accept full responsibility for that in not organizing them better.

This is more or less of a rather last minute thought on my part. This is based more or less on the manner in which they have handled these things, but I think you can see the value, and I think if you people in the future—I can promise you next year that there will be reference committees, and as we go along there will be more resolutions. More business of the State Medical Society should be handled by resolutions. Too many actions on the floor will just delay things and cause confusion. These resolutions are invaluable. Your resolutions should be in before 60 days, or they should be sent to the Executive Committee, or brought to the floor with a request for a two-thirds vote allowing them to be presented.

I can assure you that next year—I can't assure you any further than that—there will be reference committees, that public hearings will be held, and I would like to request that those of you who do present resolutions from different counties send some representative to present that resolution, and that they have a representative present at the open hearings.

Anybody else interested in those appear before the open hearings, so that the committee, when they are going into their private, closed conference will be knowledgeable about the things that they're dealing with.

I think we have accomplished a great deal today,

and I now hold the floor open to a motion for adjournment.

DR. POTEAT: I move you, sir, that the House of Delegates give the Speaker a rising vote of confidence and thanks for the expedient manner in which he has dispatched the business.

(The delegates rose and applauded.)

(The meeting adjourned at 3:45 o'clock.)

BANQUET SESSION

The President's Dinner held on Tuesday evening, May 3, 1966, in the Asheville City Auditorium, Asheville, North Carolina, convened at 7:30 p.m., Dr. Robert A. Ross, Toastmaster.

(Following the presentation of the President's Jewel, and installation of President-Elect Frank W. Jones, Dr. Jones read a prepared manuscript.)

(Recognition of the Fifty-Year Club and presentation of Fifty-Year Club Pins and Certificates.)

TOASTMASTER ROSS: I think that all of us here are fortunate, particularly you younger people, because you're living history. You are in the presence of history at this time.

I think all of us on the occasion of the Mercury flight heard a man speak with certainty, reassurance, and with knowledge about what was going on. I know that none of us can ever forget that. And this man is with us tonight, and we are fortunate in having him here to talk with us.

This is Colonel John Powers, and when Colonel Powers went into the Second World War as a combat pilot he flew missions in the Orient, missions in the Pacific. He was with Patton's Army, and you name it, and he has done it. He was in the Airlift in Berlin in the critical time when that place was uppermost in the minds of all of us.

So I would say that we have living history with us tonight, and we're delighted to have Colonel Powers with us. He has received all of the citations that the Air Force can give, and they recognize him for what he is, a superb flying man.

You have seen him more recently when, with all the confidence, he was describing the flight of the astronaut, when he had the tornado, and you've heard him talk about the forward look and the forward power.

Anyway, without being facetious, and with the gratitude of all of us here, and congratulating Dr. Paschal for having been able to get such an outstanding citizen and soldier to be with us tonight—and Dr. Paschal certainly is to be congratulated in having Colonel Powers talk with us now. We feel close to him because as a matter of fact, he comes from North Carolina, and I'm sure he enjoys this confidence, and we are especially grateful.

So we will now hear from one of the people who has helped make history in the United States. (Applause)

(Colonel John Powers addressed the group regarding the U. S. space program.) (Applause)

(The meeting adjourned at 10:10.)

FIRST GENERAL SESSION

Monday, May 2, 1966

The First General Session of the One Hundred Twelfth Annual Session of the Medical Society of the State of North Carolina, held in the Asheville City Auditorium, Asheville, North Carolina, convened at 9:15 a.m., Dr. George W. Paschal, President of the Society, presiding.

PRESIDENT PASCHAL: The First General Session of the 112th Annual Meeting of the Medical Society of the State of North Carolina will now come to order.

It is with a great deal of pleasure that I introduce to you this morning our first speaker.

I have had the pleasure of knowing him for several years. I first saw him and found out something about his work at a National Conference in Chicago that had to do with disaster medical care that was sponsored by the American Medical Association. He's been extremely active in emergency medical care over the years, and he brings to us the vast amount of information in that regard.

He is a native of New Jersey. He was educated at Yale. He is a contemporary of a number of other distinguished Yale graduates, including mayors of cities, and important representatives of government.

He had his medical education at the University of Virginia. He spent a good bit of time in Eastern North Carolina. I think this is his first trip to the Western part of our State.

Currently, he is the Surgical Director of the Veterans Hospital, Veterans Administration Hospital in Pittsburgh. His name is Dr. Francis Jackson, and we're happy to have him here.

(Applause)

(Dr. Francis C. Jackson presented an address "Revised Concepts in Emergency Medical Care" which will appear in the N. C. Medical Journal.)

PRESIDENT PASCHAL: On behalf of the Society, I would like to thank Dr. Jackson for spending time from his busy and strenuous schedule to come here and speak to us.

In addition to welcoming other guests who have arrived, I would like particularly to direct a word of welcome to the members of the Students of the American Medical Association. We are pleased to have those of you that are here with us.

We will introduce our next speaker, who has a most interesting background. He was born in Iowa. He went out, however, for his early education down to Westminster College in Fulton, Missouri, where he graduated cum laude. He set the pattern at that time for a series of distinguished accomplishments which were to follow.

At Northwestern University, he was engaged in neurophysiology of research problems and acquired an M.A. At the same institution, he received a Ph.D. with his principal research still being in neurophysiology. He graduated in medicine and was an instructor in anatomy, which formed a basis for further accomplishments.

He had his surgical training at Johns Hopkins, and at Miami, where he was chief resident in surgery at

the University of Miami School of Medicine. Later he was a resident in thoracic surgery at the Veterans Administration Research Hospital in Chicago, and he became a Markell Scholar, which in itself is of great significance.

He was an instructor in surgery at Northwestern University, and through a series of progressions finally became Assistant Professor of Surgery at Northwestern.

The University of Colorado then lured him away, and he went to Denver as an Assistant Professor, and there, after an appropriate time, he became Professor of Surgery at the University of Colorado Medical School.

He is certified by the American Board of Surgery and the American Board of Thoracic Surgery. He is a recipient of several outstanding awards. He is on the Editorial Board of Transplantation. He belongs, I assure you, to all of the appropriate organizations and societies. He is a distinguished member of our profession, and he is going to talk to us this morning on "The Present Status of Clinical Homotransplantation." His name is Thomas E. Starzl, now of Denver, Colorado.

(Dr. Thomas E. Starzl presented a slide-illustrated lecture.)

(Applause)

PRESIDENT PASCHAL: Thank you very much, Dr. Starzl. I'm sure that we are happy to have this enlightened statement about this important problem.

I would like to take this opportunity to make an announcement.

We are happy indeed to have with us today our next speaker. Sometime recently, I was in Chicago for a meeting, and our speaker was introduced. The introducer took about 15 to 20 minutes to tell of his broad accomplishments, broad and extensive accomplishments. Our speaker was going to speak only ten minutes.

I am not going to belabor the point and tell you all his accomplishments. All of you know about the President of the American Medical Association. It gives me great pleasure to introduce to you our President, Dr. James Z. Appel.

(The audience rose and applauded.)

(Dr. Appel's address concerning the AMA role in Medicare is tendered to the North Carolina Medical Journal.)

(The audience rose and applauded.)

PRESIDENT PASCHAL: I'm sure we feel that we have been issued a challenge. I think that we in North Carolina, and those of us in the Medical Society of the State of North Carolina, accept this challenge, and that we're going to try to provide leadership, expanded leadership, in working with our Governmental agencies in trying to guide and to provide guidelines for the rendering of the service, and care which only the medical profession and the allied fields can provide.

On behalf of the Society, I express my gratitude to our President of the American Medical Association for being here with us and bringing to us this significant message.

Thank you very much, Dr. Appel.

Our next speaker is and has been since the first of January the Acting Health Director succeeding Dr. Norton, who resigned.

Jake Koomen is a native of Bristol, New York, and graduated from the University of Rochester School of Medicine.

In 1954, he was assigned to the North Carolina State Board of Health by the Epidemic Intelligence Service of the U. S. Public Health Service, and he became Assistant Director of Epidemiology for the State Board of Health.

In 1957, Dr. Koomen received his Master of Public Health Degree from the University of North Carolina School of Public Health at Chapel Hill.

For a four-year period beginning in 1961, Dr. Koomen served as the Assistant State Health Director.

He has been the recipient of the Reynolds Award given by the North Carolina Public Health Association for outstanding contributions in public health in North Carolina. He holds membership in a number of organizations other than our own that relate particularly to his field of endeavor. He has been the author and co-author of a number of articles and publications in the field of epidemiology. He holds the rank of Senior Surgeon in the U. S. Public Health Service. He is currently a visiting professor at the University of North Carolina School of Public Health.

He and Mrs. Koomen have four children, and they live in Raleigh, and we're happy that they are in our community. He is an Elder of the White Memorial Presbyterian Church, and it is with great pleasure that I introduce to you Dr. Jacob Koomen, our Acting Director of the State Health Department; Dr. Koomen.

DR. JACOB KOOMEN: Dr. Paschal, ladies and gentlemen: I should like to talk to you this morning about the North Carolina State Board of Health role in Medicare. You have had an eloquent exposition by Dr. Appel of his views and our views about this legislation.

My background is in epidemiology, and I tend therefore to look at this legislation and our role in it along these lines; namely, the matter of time and place and person.

You have had a fine discussion of how things got to be, and wish now to amplify upon certain facets of this as they relate to our work.

We have of course, as has already been pointed out, to do the impossible, and this will only be an end—successful results—for the physicians in the state and the remainder in the nation, many unfortunately in areas by no means so far advanced as this one. Any facet of health one wishes to explore in North Carolina, one can make a case ordinarily without exception for why we lead in one field or another.

First, the State Board of Health will have the function of certifying institutions for a deadline precisely close, as already pointed out. So far as the hospitals are concerned, this is to be July 1st. This is also true of Home Care Programs, and only another deadline six months hence for extended care facilities, which in this State we believe, as elsewhere, will largely be nursing homes or rehabilitation centers.

A second function will be to provide consultation to all who wish it. How they might come into this system of participation, what will be required of them in the way of paper work, in the way of support, in the way

of management. And finally to aid in the coordination of programs between these.

In North Carolina, we have 176 licensed hospitals, that is, licensed by Medical Care Commission, hospitals other than those that are Federal. Of this number 106 are already approved by the Joint Commission on Accreditation of Hospitals. These are then some 84 per cent of the general hospital beds in the State, approximately 65 per cent of the hospitals, about 64 per cent of the general hospital beds in North Carolina.

There are, of the group that I told you about, 144 general hospitals, three private psychiatric hospitals, and four tuberculosis hospitals, the latter all approved by the Joint Commission on Accreditation of Hospitals, thereby sparing us much work, since these will qualify essentially automatically under the Medicare system. They will, of course, need to show compliance with the Civil Rights legislation, and there, as you are aware, North Carolina is much farther ahead than its neighboring states to the South of us.

Each must demonstrate that it has a utilization review committee and a plan of operation: but as I will say later, this is to be along far more liberal lines than were originally conceived, and this comes out of the sort of discussion that Dr. Appel has given to us this morning.

Virtually automatically then, for institutions which wish to participate, will be the clearance of those already approved by the Joint Commission on Hospital Accreditation, requiring of them only evidence of compliance with the most recent Civil Rights legislation, and the demonstration that there is a utilization review committee and a plan of operation.

There are some 60 general hospitals which are not accredited by the Joint Commission on Accreditation, making up some 16 per cent of the hospital beds. Quick arithmetic will tell you, therefore, that these must be small institutions, and indeed the bulk of those so small as to not qualify around the 25-bed system in which the JCAH does its examination. Indeed the Medical Care Commission for North Carolina licenses institutions which have two or more beds.

We have already sent long since the necessary materials to the hospitals which would qualify by virtue of their ordinary daily work. We have received from a large number of them replies as to their wish to participate. From 31 of the general hospitals, we have not received replies, but I say again that in the main, these are the smaller institutions. Indeed, of the 31 from which we have not heard, the eleven smallest would have only 84 hospital beds altogether.

What we have done in the certification system is to combine with the Medical Care Commission. They are the licensing agency in North Carolina. All of you have worked with this group. Some of you now and some of you in the past, and some of you in the future, will sit on this commission. This avoids overlap of function. These are people regularly in and out of hospitals. It will use personnel more efficiently and will avoid the matter of multiple visiting teams. It will avoid the matter of as much avoidance as can be of multiple

paper work. And hopefully it would use time efficiently well.

I might say that the survey of a hospital would require approximately three days, and since in the bulk of our general hospitals this can be avoided, much time and energy will be saved.

There are many areas of concern and anxiety around this. A number you have already heard. We, too, are concerned over the matter of overutilization, and perhaps in some areas underutilization. But perhaps most anxiety-producing of all is the stipulation around the utilization review committee which must be a part of the operating plan of both hospitals and extended care facilities.

We are anxious over the situation. The institutions are anxious, and the physicians who may or may not serve on these committees are anxious, and well they might be. These may be set up from within the institutions having two or more physicians in them, and such other personnel as local conditions would suggest or may be mandatory, or in the smaller institutions, perhaps these may be set up by a County Medical Society, or such other group as the hospital, the local practitioners and we might agree upon.

But I repeat that much less rigidity is to be injected into this from the plans which were originally seen. Much greater local determination will be permitted so that local practice may be seen here. They will review such matters as length of stay, the need for admission, the type of drugs used, the whole range of diagnosis and treatment, the use of consultants and the quality of care.

I want to interject at this point that the idea of utilization committees and utilization review committees is not new: indeed it's quite old. But these have seldom captured the imagination, ours or the hospitals, because of the fact that most of us are not comfortable in the situation where we may appear to be reviewing the work of our associates, or the reverse.

These matters do promote anxiety. We are hopeful that much of this can be bridged by interchange in these committees, and by pointing out that while there is considerable authority around them, it is the physician who admits and discharges, and treats, that the utilization review committee will have certain benefits.

It will know when a patient cannot be discharged after a prolonged stay, because the community either has no extended care facility or other program to which these individuals might go. It will know too why individuals are staying longer than necessary, and a lesser length of time. And thereby we believe we will be able to establish better plans for hospital construction and extended care construction.

But as I have indicated, while perhaps 20 to 25 per cent of JCAH accredited institutions in this country have utilization review committees, in general, they have not been widely accepted, and many institutions which have them have committees which exist perhaps on paper only.

One of the concerns of the physician has been his possible medical-legal role in this. The suggestions by the committee put in writing that a patient has stayed

sufficiently long and the possibility of some unfortunate disaster after such an institution has discharged such an individual has caused many physicians to look with alarm about their possible role in this. But the committee does not have true legal authority in this. It is a matter of discharge and notification to the individual physician. However, I might add in fullness that here time alone will supply some of the answers that we are now looking for.

Then I might say—and perhaps many of you know—that the 65-year-old or above citizen is on the average twice as frequently in hospitals as those below this age group; and furthermore, their stay is above twice as long. The factor is not precisely four; it's in the range of 3.9. And whatever the guesswork as to the utilization of institutions, it seems almost certain that there will be a glut initially of people going into hospitals. Nationally, the guesswork on this might range from 10 to 40 per cent in increase. Apart from this, one might speculate rather quickly that in those communities where there is high utilization of hospital beds, that this will soon bring about the need for review of hospital construction plans.

We have had in the utilization review committee some 66 plans submitted to us, 36 of which have been forwarded on to Atlanta. We expect a number more will come in this week. I want to repeat that the rules as they are being brought about in this permit us to infer and to presume the functions of the hospital far beyond what seem to be the expectation at the beginning, and that local practice will be very heavily seen in this.

There are other areas of concern. Of course, the matter of paper work, the vast quantity of data to be kept. We will need to look for data simplification systems, and we and you have been working to make this as simple as possible. Already the burden of paper work in the practice of medicine is a perfectly enormous one, and we're trying desperately therefore to keep it down.

The promise that we will be confined to brevity in record-keeping we hope to maintain, so that the physician's true calling will not be diluted out by the things which he must record on paper.

The matter of reasonable cost which you saw reflected yesterday in resolutions before the House of Delegates is of concern to us too. What does this definition really mean? It may mean some things hoped for, that in the payment of reasonable costs, we may be able to better our hospital facilities, our dietary practices, our libraries, our laboratories, and our buildings. But here too answers will come out of the future.

The shortage of manpower; the next dawn will see very few more health practitioners. And without meaning to be facetious, the current pace at which health practitioners are working will perhaps be such that we will look for devices to add more hours to the day.

Be that as it may, most of us would have wished an opportunity for the creation of more health manpower prior to such legislation, so that we could have a great team ready and running in numbers. In North

Carolina, we do have a large team, and we have an unbeatable one in the matter of quality. But as for numbers, all need more. The wide shortage of health personnel impinges particularly in the face of such legislative demands.

And then the many questions unanswered, ones which we cannot answer because answers are not available, and questions which we perhaps not even now can foresee, because you will recall that not only are we involved—you and I the Association, the various societies, the state agencies and the Federal ones that have to do business, the fiscal intermediaries, all important, the institutions, the hospitals, the extended care facilities, and so on—but in North Carolina an estimated 367,000 citizens.

A modest background of statistics will point out to you the perfectly unbelievable opportunities for misunderstanding and, the reinforcement of what Dr. Appel said, for conveying to society-at-large, and particularly those involved, the absolute necessity of data around this, what may be expected and what may not. In particular we have the feeling that society-at-large may not understand that this is a system for paying for not providing medical care, the reasons for which are clear too.

In the matter of extended care facilities, we have licensed in this state some 84 nursing homes, less than we'd like, but our standards both for licensing and for considering what is and what is not a nursing home are rigid ones, and this makes comparison between this and many others particularly difficult, because definitions vary over the country.

The State Board of Health has for some years been the licensing agency, and for this reason we occupy a role in this particular situation similar to Medicare and the Medical Care Commission. We will of course be hard put to have all of this in order by January of next year, but we are well along by virtue of the fact that we are the licensing agency and have an active program.

Such must provide skilled nursing care and a variety of other services.

Let me add too that over most of the United States the average age of occupants of nursing homes is 75 to 76 years of age. As conceived in the Medicare system, these are not custodial settings, the extended care facilities and nursing homes as they currently are now, but are way stations either to a patient's home or to home care programs led off by three days of prior hospitalization; and they will be suited and indeed must be suited to all age groups.

One occasionally does find the young and middle-aged in nursing homes, but it is relatively seldom. The whole complexion of what a nursing home is almost certain to be changed in fulfillment, if there be fulfillment, of this legislation as a place where there may be care, excellent care at a lesser cost for those who cannot get along without the multitude of services required of hospital care.

Facilities are too few. Those we have are in fine shape, in the main, and because we serve as the licensing authority, we have greater opportunity perhaps in

this state, since the standards have been rigid from the very beginning.

Let me now go on to the matter of independent laboratories which will also come under this. These are laboratories other than those operated by physicians for their own patients, laboratories operated by hospitals for their clientele and those of their staff. The precise number of these in the State we are uncertain about. Only some ten states license such laboratories, and perhaps another five register them. Thirty-five states neither license nor register private laboratories. It's true that some of these are approved for syphilis virology and a variety of other tests, but there is not a licensing law or registering law in this state and many others.

For this reason, through questionnaires of you and many of the associations involved, county health departments and hospitals, we have come to believe that there are perhaps some 200 of these in the State, and they too may be, if they wish, part of the Medicare system. The absolute number, however, we don't know.

Then I come to home health services. These are to provide within the home or the usual abode of the individual such services, nursing, skilled nursing care, and at least one other, which may be occupational therapy, speech therapy, physical therapy, medical-social services, and so on, to make up a complete component of care within the home.

It would seem that in North Carolina such will largely be supplied through county health departments, of which we have one for each county. You know that in North Carolina we have, I believe, only two true visiting nursing services in Tryon and in Forsyth County. We have going some 37 of these programs in North Carolina at this time, in some 32 health jurisdictions. And so we have a considerable number already at the race line.

But I might say that, for sake of completeness, many services will be needed, will have to be added to most of them. But because there are county health departments in each of our counties, there is a starting place for this, if those people in the county feel that the place to put things is in county health departments.

This obviously must be combined effort. There is little point in building such a service if physicians or hospitals do not wish it. Indeed there are some hospitals in the state who do carry on certain extended care functions, and these various functions may be done by hospitals, by private agencies, by government, and so on. Time there will answer it.

We are particularly fortunate, I think, not only around the system of county health departments, but because in the schools we have, as you know, three outstanding medical schools, a reasonably large number of nursing schools, and the whole complement of health schools, say, for a college of veterinary medicine. Even that you know is now closely related to human health.

Also, in building home care programs, we would wish for programs not suited solely to just those who are 65 and above, because the operative experience and the obstetric experience of those below of course is a con-

siderable one, and one would hope that over the years a program of home care can be fashioned which would be suited to all age groups, and to the particular needs of the community in which it is found.

These are to have advisory not utilization review committees, but advisory committees which will have one physician, one nurse, and such others as local practice would seem to make desirable. And above all, I reiterate, there must be consultation, and beyond that leadership with the physicians in the community and the hospitals as to whether they wish it or need it.

I have spent most of my time on the first of the three items—certification and what this entails, certification of home health programs is also to be done by July 1st of this year, now preciously close. There is to be consultation—and I referred to that earlier—among those and for those who wish to qualify, so that we may aid them, help them in any way they desire, and in any way we hope—we know North Carolina institutions practice their arts well. This may not be at the moment an extensive service. Indeed we have been urged by the Social Security Administration to begin small. The Social Security Administration is particularly proud of the fact that it has never had to discharge employees, have a reduction in force, because it has always begun programs with as small a staff as it can manage, and then built it up accordingly. And we have along these lines been urged by them to begin with a small staff, and to increase as demand increases, if it does. For this reason, our program around the present state of affairs involves three professions and two secretaries, and we hope to add a nurse and a dietician.

Those institutions which wish to qualify, when and if they need our services, we can be brought together. We will look over their situations to make suggestions and to resolve such differences as may exist.

Then we are to supply a coordinating service for, as pointed out, the nursing homes will need to have a working agreement with a hospital for the orderly transfer of patients, and especially the orderly and quick transfer of records, so that there may be no gaps between hospital care and the next step in the continuum of care.

Hospitals need have agreement with only one nursing home, or the reverse, because in fulfilling such an agreement, it can be presumed that agreement with all would have been fulfilled. And this too I think is rather model in the avoiding of paper work.

We have been told by the Social Security Administration that we are as well along as one might be in view of the progress of the guidelines, and that we lead those area states about us. The chairman of our Board, and our whole Board, is dedicated to—by that I speak not only of the policy-making group, some of whom are here today and will be coming later, but the staff as well is dedicated to making this as simple as possible within the framework of the legislation before us. Furthermore, it is dedicated, as are the national groups—pointed out again by Dr. Appel this morning—to as large a voice as can be felt in this locally to preserve the elements of democracy which we fight for so hard.

Then it can only be made effective obviously by the

physicians in their practices who admit and discharge, treat and prescribe.

I must say that the Medical Society of the State of North Carolina was not only quick with vigor in stepping forward to aid in this. I might say the same of the Hospital Association, our own State Board of Health and the Physician Intermediary. I might add as an all but final note that I would be as comfortable addressing them as I would you in praise of what they have done to this point.

Nationally, I know many people have spoken about what has been done about national committees. Let me tell you that within the State the vigor of its practitioners in all health efforts in stepping forth, in trying to aid us, in supporting us, has been phenomenal, so that our role has been made a comfortable one, and we have been strongly supported, I repeat, by all of these.

They have put in enormous amounts of time, energy, vigor of thought, and of planning, sitting down with us to discuss the needs and how this might best be done.

We, too, agree about the necessity for the spread of information, so that we—and I speak of all of our citizens—might understand this, because not only are there 367,000 individuals approximately who are eligible, but there are their families who have many questions, and many relating to the physician, the hospital, and the fiscal areas here.

You have permitted me then to come before you. This gives me an opportunity to say what our responsibilities are; but beyond that, it gives me an opportunity to indicate that you, and those with whom you have worked, will, it appears—if it can be done—make the impossible in this area possible. It permits me also to thank Dr. Paschal and those members of the committee who have invited me to come, and it permits me to thank you who have listened so attentively.

Thank you very much.

(Applause)

PRESIDENT PASCHAL: Thank you, Dr. Koomen.

I think it very appropriate to recognize the excellence of the job that has been done by the Committee on Scientific Works in arranging this program, and Dr. Koomen's remarks are only another indication of their wisdom in their choice. Their wisdom will be further demonstrated by what we hear from our next speaker.

Our next speaker is a native of Cambridge, Massachusetts. He was an assistant in pathology at the Peter Bent Brigham Hospital, on the surgical service of the Boston City Hospital. He participated in the military as a Major in the Medical Corps, was later a research fellow in the Department of Legal Medicine at the Harvard Medical School, associate and medical examiner of Suffolk County in Massachusetts.

He is an assistant and has been an assistant professor of Legal Medicine and Acting Head of the Department at Harvard Medical School. He is pathologist at the Massachusetts Department of Public Safety. He is a lecturer of legal medicine at Yale, Tufts, Boston University, and holds an honorary professorship in that regard at the University of Southern California.

He is a consultant with the Armed Forces Institute

of Pathology. He is head of the Department of Legal Medicine at Harvard, Medical Examiner at Suffolk, as I have said, and is a Rockefeller Traveling Fellow, lecturing in Forensic Medicine at the University of Southern California, consultant pathologist for the Federal Aviation Agency.

He holds a membership in a number of important societies relating to forensic medicine, and we in North Carolina have a number of people who are also interested in forensic medicine in expanding our medical examiner system throughout North Carolina, and we believe that what our speaker will tell us this morning might have impact and influence on expanding this system.

Our speaker is going to speak to us on "The Medical Examiner's Role in Exoneration of the Innocent," and his name is Dr. Richard Ford of Boston, Massachusetts. We are happy to have him here.

(Dr. Richard Ford presented a slide-illustrated lecture.)

SECOND GENERAL SESSION

May 3, 1966

The meeting convened at 9:15 a.m., Dr. John McCain presiding.

CHAIRMAN JOHN MCCAIN: I am John McCain, and I was notified last night that I am to be one of the presiding officers at this session today. It was a real surprise to learn I was to be presiding officer in place of Dr. Paschal.

In my apprehension, I was reassured in actuality there would be few present to hear my opening remarks, only those who did not want "Sex for Breakfast." I'm glad to see that you have no problems in this area.

Actually, I have a very pleasant duty this morning to introduce an old friend of mine. He is a Diplomate of the Board—specialty in Pulmonary Disease, life member of the American College of Physicians, Fellow of the American College of Chest Physicians, member of the American Trudeau Society, President of a district medical society, member of the North Carolina State Board of Health, active on the staffs of two general hospitals, and a consultant in chest diseases in five other hospitals in Piedmont, North Carolina.

You can see that he is well qualified to moderate the panel discussion this morning on Pulmonary Insufficiency.

Without further ado, I would like to turn the program over this morning to Dr. Joseph S. Hiatt of Southern Pines.

(Dr. Hiatt assumed the Chair as Moderator of a Panel discussion "Pulmonary Insufficiency.")

MODERATOR HIATT: Thank you, John, for your remarks. I am here because of two reasons. One is if you have had a disease, you become an authority on it, at least you think you are; and the second reason I would say would be due to the things I learned from Paul P. McCain.

Our program today is one in which we don't need to bring up any reasons why this problem should be discussed. Except for Dr. Waring's specific remarks con-

cerning systic fibrosis, basically we will deal with pulmonary emphysema, the number two cause of disability in the United States today, one of the three major diseases rating in morbidity and mortality.

Without further ado, we would like to begin our discussions, the first discussion with a roentgenographic diagnosis by Dr. Charles Bream, Professor in Radiology at Chapel Hill.

(Dr. Bream presented a slide-illustrated lecture on "Roentgenograph Diagnosis.")

MODERATOR HIATT: We are delighted to have with us our out-of-state speaker who is Professor of Pediatrics at Tulane University Medical School. Dr. Waring!

(Dr. William W. Waring presented a slide-illustrated lecture, "Pulmonary Disease in Childhood.")

MODERATOR HIATT: Dr. Sieker found he couldn't be in two spots at the same time, so he's in Atlantic City instead of being with us today. We regret this very much, but we are equally delighted to have with us Dr. Johannes Kystra, who is at Duke, Assistant Professor of Medicine in Physiology, and works with Dr. Sieker and his group.

I don't think we understand the problems of emphysema and can afford any proper treatment unless we understand the physiology. The pathology is still value as to etiology. We'll let somebody else worry about that. In order to appreciate the situation these patients get into and how to get them out of it, we have certainly got to know the biochemistry and the physiology that exists in order to give them relief.

It's a pleasure to have Dr. Johannes Kystra, who is not only an M.D., but a Ph.D. in Physiology.

(Dr. Kystra read a prepared manuscript, "Chronic Bronchitis and Pulmonary Emphysema," to be sent to Headquarters Office.)

(Dr. Howard H. Bradshaw presented a paper "The Role of Surgery in Pulmonary Insufficiency.")

(Applause)

(Dr. McCain resumed the Chair.)

CHAIRMAN MCCAIN: Thank you very much for this very excellent discussion on pulmonary insufficiency. I can think of no more timely talk. It was presented in wonderful fashion and we are deeply indebted to you.

You heard of the poem—

There was once a Program Committee

Who thought they were sitting quite pretty

Until one speaker sent word

that he would not be heard

And that no substitute—what a pity.

Well, for our program yesterday, one of them sent word that he was not able to attend. However, we are most fortunate in that we do have Mr. Gilbert Hartis of Parke Davis to make some presentations of pictures about the history of medicine from the Parke Davis Company.

MR. GLBERT HARTIS: More than ten years ago, Parke Davis decided that it would be very fine for us to produce a series of stories and pictures on the history of medicine. The author and artist that we chose for this job traveled more than 250,000 miles through eighteen different countries in the world to be sure

that he had the proper information to make these pictures authentic and true.

Our primary aim in producing this series has been to tell the story of your profession to the public, and in an interesting and effective manner. I'm sure you will agree that this is being accomplished very effectively when I tell you that we receive 50 to 100 requests each week from the public and people in the field of education for reprints of these stories and pictures.

Nearly a million copies of these prints have been distributed throughout the world, and the originals are continuously being shown in the picture galleries and in educational institutions.

It gives me great pleasure, both personally and on behalf of Parke Davis, during this, our Centennial Year, to present to the North Carolina Medical Society these prints that we hope you will use in your office in Raleigh.

(Applause)

CHAIRMAN MCCAIN: Thank you, Mr. Harris. They certainly are lovely, and on behalf of the Medical Society, I would certainly like to express our appreciation to you and Parke Davis for making these available.

For my real honor of this convention, I have the pleasure of presenting to you a man whom you all know, and to whom we are all greatly indebted: a leader who has carried our Medical Society forward in this past year in the highest tradition of the medical profession.

To give us his Annual address, our own President, Dr. George Paschal.

PRESIDENT GEORGE PASCHAL: It is with appropriate humility that I now come to my part in the program, particularly after a long series of papers and presentations of such excellence. I have chosen today as the title for my remarks "Let Us Look to the Future Together."

(President Paschal's address will appear in the N. C. Medical Journal.)

(The audience rose and applauded.)

CHAIRMAN MCCAIN: Thank you, Dr. Paschal. We are all deeply indebted to you for the dedicated leadership and direction you have given us this year.

(Announcement)

(The meeting adjourned at 12:30 o'clock.)

THIRD GENERAL SESSION

Wednesday, May 4, 1966

The meeting convened at 8:55 a.m., Dr. W. Otis Duck, 1st Vice President, presiding.

CHAIRMAN DUCK: I now declare the Third General Session of the 112th Annual Meeting of the North Carolina Medical Society officially convened.

The first item on the agenda for the morning, as you will note from your program, is a Conjoint Session of the Medical Society of the State of North Carolina with the North Carolina State Board of Health.

This Conjoint Session is to be presided over by a person who is no stranger to you, having been your Past President, and a leading orthopedist in the State of North Carolina, Professor at Duke University, and I pre-

sent to you at this time a man who continues to be a friend indeed to the profession of medicine and to the Society of the State of North Carolina.

Dr. Lenox Baker. (Applause)

DR. LENOX D. BAKER: You're very kind. As far as my presiding, it will consist of introducing for the first time under his present title, our Director of the State Board of Health, who has been in this office since January; Dr. Jake Koomen, whom we have all heard before, will give you your annual report.

DR. JACOB KOOMEN: Dr. Baker, Mr. Chairman, Mr. President, Ladies and Gentlemen:

This is the time when we annually report the stewardship entrusted by the Society and the citizens of the State of North Carolina to the State Board of Health. I recall to you that the State Board of Health is a nine-member body, four of which come out of the Society, and five of whom are appointed by the Governor.

Those from the Society are Dr. Goodwin, Dr. Raper, Dr. Hiatt, and Dr. Steiger, all well known to you for their achievements within the Society, and outside of it. The Governor's appointments are Dr. Baker, whom you just heard introduced with the appropriate praise due his achievements, Dr. Dawsey, who represents so well the veterinary profession, Dr. Cline in like manner the dental profession, Mr. Koonce, who could not be with us today, the profession of pharmacy, and Mr. Lackey, who represents the dairy interests of the State, all extremely important in the health area.

In presenting a brief accounting of what we have done, I should like to mention first that this year brought the retirement of Dr. J. W. R. Norton as State Health Director after a period of nearly 18 years in this office, one of phenomenal growth and progress. He will be with the State Board of Health in the future as the Director of the Division of Local Health Service.

The year, of course, has been an exciting one, because perhaps at least in my lifetime, yours as well, this is an era of great revolution in research, in knowledge, in all the fields of health that have to do with prevention, with cure and rehabilitation. And your Society, as reflected in us who belong to it, as reflected in the citizens, as reflected in your responsibilities, are all in this.

Further than that, we share the anxiety over the really terrible shortage of manpower, and we look for ways of extending the arm of those already working.

The North Carolina State Board of Health is involved in some 30 programs. Of these, several touch you frequently, and some of these touch you each day. We have been well supported by the Society, and obviously, of course, we have been well supported by the Board; and we trust the reverse is true, that we have the support of them in like manner.

I should like now briefly to talk about the functions of the various divisions, to hit only highlights in discussing 30 programs. Obviously, it is not possible to mention them all, and we have in turn from year to year talked about one function or another.

I should like to give you a general review of what is going on in public health in North Carolina.

Firstly, I mention the matter of money. There is, of course, not enough spent on health. There will be more in the future. But North Carolina, which as you know is the eleventh most populous state, and which expects to have five million people in September of this year, in the domain of direct public health spent \$19,600,000 last year, last fiscal year. And this represents an increase of better than three million over the year before.

Perhaps surprisingly, an increase of better than \$800,000 came out of increased appropriations by local bodies. Public health is very well supported by the citizenry at the county level. Our staff has grown. The State staff now stands at the level of 432 staff members, and the local health departments have another 1,500, close to those they serve.

North Carolina has one of the largest public health organizations in the nation, as suits its particular health needs, and if I might say so as an outsider, it also has the best.

We distribute, as you know, the Health Bulletin, a circulation of 47,000 per month. We have a public health library of our own, and more than 8,000 visitors were recorded there last year. Our film library known to all of you, since you are frequent borrowers from it, at the colleges, the schools and the churches, had a circulation of almost 43,000 films last year.

The recording of data in organizations such as ours leads to astronomical numbers of pieces of literature, important ones, birth certificates, death certificates, and all of our correspondence. Of these, we had more than 277,000 pieces permanently recorded. And I might say that lest you feel this is an outgrowth of red tape in North Carolina Government, it's not. North Carolina Government is a superbly efficient, smooth-running government, virtually devoid of the sort of criticism—perhaps I should say devoid of the sort of criticism one so often picks up in America that has to do with red tape. Our governmental systems are efficient and simple, and there is not red tape, in my estimation.

Finally, in the matter of publications, we supplied to the citizens not only the health bulletin, but a great gamut of items about particular diseases and conditions in states.

I move now to the Division of Dental Health. Let me say preamble that in presenting before the Advisory Budget Commission one year, I discovered were the dentist as it ought to be for North Carolina children, that those in the first six grades would have some 17 million teeth altogether. Think of the opportunity in the field of dentistry. Think of the number of dentists we have; and like all health professionals, how many more we need. But they work desperately to correct, to cure, and to prevent, and I will have something to say about prevention.

Now only in the personal office prevention sense of the word, but as you know at the State Board of Health, we have a reasonably large staff of dentists who function with the schools in prevention programs, some curative aspects. Here too we have expanded this, so that we now have an internship in Public Health in Dentistry, because an increasing number of dentists are

turning to public health as a career, and their importance is being recognized.

Last year, for the first time, we had a Federal appropriation specifically geared to dental needs. We have had interest in oral cancer, and through these programs, in cooperation with the practicing dentists, five cases of oral cancer were discovered in '64 and 13 in '65.

And finally, of great interest to us all, the dentists and the engineers, as you know, and our North Carolinians, have pushed the use of fluoride in the water whenever this is possible, to work vigorously to enhance and increase the number of communities using it.

There are now some 84 towns who fluoride their water. They cover a population of about 1.4 million, and we can now state that 31 per cent of the population is covered by fluoride water supply.

I could go on, but in the interest of time, let me go on to a third of our seven divisions, Epidemiology. Now the term epidemiology is a broad one and has to do with events among the people, and quite clearly all of man's endeavors would fit into this.

At the State Board of Health, the Division of Epidemiology fills many of the functions filled by other divisions in other states which are labeled Divisions of Preventive Services. It works in communicable diseases, in occupational health, in radiation protection, tuberculosis, venereal disease, and it records the births and deaths, and the marriages and divorces, and it is interested in accident prevention.

But among the things that were looked into were the matters of large epizootic or Eastern encephalitis, a follow-up program of all birth certificates to insure that North Carolinians be adequately immunized against those diseases for which childhood prevention is possible, widely accepted in this state.

We looked into and followed up smallpox vaccination to see what kinds of reactions we were getting, and at the State Fair this past year, in cooperation with the Medical Society, a booth was maintained for tetanus immunization of those who would stop by. A great many were immunized. This was a successful project.

There is more to be said. As you know, there is an epidemic of syphilis nationally, but this has been controlled and halted in North Carolina; and further than that, venereal disease control and instruction has been given in any number of school systems.

We have modernized, so to speak—modernized is perhaps not the correct word, but we have put in a new tuberculosis program in line with national suggestion.

Because of widespread interest in drowning in the State, we lose too many in drowning, often in multiples; there were a number of drownings last year in which four died simultaneously. We followed these up along epidemiological lines, and of course we worked closely with the education system, whether this be at the elementary school level, or high school and college level, in implementing our programs with them.

All of the birth certificates prior to 1945 have been microfilmed, and last year, to add to our armamen-

tarium, we had 97,000 births, 42,000 deaths, 40,000 marriages, and 11,000 divorces.

I might inject a note there. The common statistical data which says that one out of every four marriages is dissolved by divorce would appear to be borne out by a casual glance at our data, about 40,000 marriages and about 11,000 divorces.

Let me add that this is a false statistical base. It is not the 40,000 who married one year out of which 11,000 are divorced. The 11,000 who are divorced come out of all North Carolina marriages accumulated at that time, and the fracture rate of marriages is far low.

Let me say a word about the laboratory, a large organization, a four-story building processing better or more than 650,000 specimens last year. Highlighted should be the fact that in cooperation with personal health, a new program to follow up the possible occurrence of phenylketonuria was begun and a highly successful one.

You know that in the management of this metabolic defect, if this can be discovered early, there can be the prevention of important destructive effects. Further than that, the saving of a great deal of personal and public money in the maintenance of those who become mentally defective, if not adequately treated.

In air pollution, water and occupational health chemistry, the role of our chemistry program also increased. Again this year the amount of cancer cytology, especially cervical cytology, became of more interest, and the infectious disease always with us since man began more precise techniques in the management of streptococcal disease and syphilis made possible advance there.

I could not speak without saying some words about our Local health division, the division of which Dr. Burns Jones had been chairman until he came into the role of Acting Assistant State Health Director, a very important role in the State. He was Director of that division. Dr. Norton will succeed him in the changes that have taken place.

We do have in North Carolina, and have had for nearly twenty years, a local health department in each of our counties. Some of these of course are combined in neighboring counties for the sake of efficiency with a good Health Director serving many counties.

But here too the role is one of increase in service. We do have unfortunately a considerable number of vacancies because in this era, and in this area, there are too few people in the health professions, a shortage felt worldwide, and felt therefore among our health directors. We wish that there were more. We look for an expansion in their efforts.

In cooperation with the Economic Opportunity Act, we have been educating people in the health education field. We have done a great deal of education with in the nursing group through self-teaching systems in the way of correspondence.

Then too, we have for emergency purposes stored in the State some 50 disaster packaged hospitals, so that should huge emergencies occur, these can be unpackaged and used. They are 200 bed hospitals. These are

pre-positioned around the State for disaster purposes. Fortunately, we have not had to use them.

We have sponsored a course in medical self-help, so that should there be great disaster, those not close to medical care could subsist, we hope, carry on, we hope, through systems of self-care.

We have been working in the field of migrant health, important in North Carolina. Not only do we take from the migrant stream, but we add to it and of course crop harvest is dependent in part upon these, and through increased sanitation and work in this area, we have improved our programs there too.

I come now to the Division of Personal Health, of which Dr. Jim Donnelly, a member of the Society, is Director. There are programs in crippled children, in correction of defects, school coordinating service, which is done between our organization and the Department of Public Instruction; and while more might be said, perhaps at this point a word about their relationship to Medicare is indicated.

This will be a program at the Federal level, and those of us in the States who relate to it, which in size is difficult to project. There are more than 367,000 North Carolinians who will be eligible for this by virtue of the fact that when it begins, they will be 65 or over. In addition to that, all of the health personnel will be effected, as will the institutions with which they associate, not to mention the fiscal intermediary, Pilot insurance for Part B, and the Blue Cross for Part A.

It will touch the lives of all of us, our families, our elders, and our institutions.

Excellent progress is being made. We are told that we are as far along in this as the guidelines will permit. But we are already off to a good and running start, though always one would wish to be farther along. But we are off to a good and running start because we have a good agency licensing hospitals in the State. We have a high proportion of hospital beds already accredited by the Joint Commission on Hospital Accreditation. And these will virtually automatically be certified.

The three C's with which we work are certification of the institutions, consultation with them, as they wish for and ask for aid in how they might proceed, should they wish to participate, and finally coordination, because these institutions will need agreements with each other, ordinarily only one with another, so that patients may be efficiently transferred from hospitals, to extended care facility, to home care program.

I had opportunity to discuss this at length at the First General Session on Monday. But let me add as a final word that we are told we're as far along as can be. Your Board is dedicated to having this, as is the Society, the best program in the United States.

We have had superb cooperation. I use the word advisedly, between our parent policy-making board, of which Dr. Baker is President, whose members are in the audience, the State Medical Society, the Hospital Association, and such others as have direct relationship with the Blue Cross people.

I continue to a few closing remarks.

The last of our divisions is the one in Sanitary Engineering. It has been said, and I believe wisely, that more

freedom from communicable disease has been bought and brought to us by sanitary measures than any other. Whenever we increase our cleanliness, our education, improve our housing, improve all of those things in the broad scope of human welfare, and when we begin to think of sanitation, we improve man's lot. It increases his life. It increases his freedom from disease. It increases his usefulness.

For that reason, among the oldest public health measures are those designed to improve the environment around us, and these days, as you know, that includes not only cleaning it up in the microbiological sense of the word and making it free of disease, but in addition to that, it already includes and will in the future include beautification, because beautification is often no more expensive than any other system and sometimes it's cheaper.

The Sanitary Engineering Division, in long and vigorous action, looked with great pains at the water supply this past year, some 156, adding to those already in existence. We now have a total of 887 supplies under supervision, and as I noted earlier, 86 towns now have fluoridation of water.

We have looked at—as you know when you travel through North Carolina—you see in our restaurants grading signs. Those of you who travel considerably look first at grading signs for the large blue A, because this tells you much about the institution. You see it posted in hospital lobbies, applying only to the kitchen. But in many years of effort and in close cooperation with the restaurant industry, the food service in North Carolina has been made a fine one.

In the matter of some of our specialized areas, for instance in the matter of shellfish, there we worked for a long time with those who are in charge of this, but now we have had a more legal arrangement made between us from the informal one which has been in use for some forty years:

An inspection program, one in which we have manpower, one in which we have specialized abilities and funds to carry this out, because North Carolina is an important shellfish state.

We work with the growers and the operators at migrant labor camps. Those of you who are familiar with them in years past know that those oriented to sanitation would quickly see much to be done, and here too by sanitation the conditions of the workers improve and so does the field efficiency.

We have looked cooperatively into school water supplies. When you think of perhaps about the one million youngsters in North Carolina public schools, when you consider how seldom one sees a newspaper article, and I praise the press for their quickness in picking up food-borne illness—consider how infrequently, indeed rarely, one sees food-borne illness, school related, think of one million children, think of the meals served per year, and think of the many possibilities for error, and then think of our almost spotless record in the serving of school meals.

Indeed when there are food-borne outbreaks in North Carolina, one usually sees them outside of the regular food services, commercial or school. And following

up the school water supplies, 112 were looked into this past year, as were their sewage systems, and where improvement or correction was necessary, this was done.

We worked a long time in the field of insect and rodent control. You recognize that there are many diseases of nature which were once borne to man, and many still occur among us and which come out of the insect world, either from animal by insect to man, from man to man by insect, or from the insect itself perhaps to man. The most striking of these is the salt marsh sputum control program. Last year, 10,000 acres of marshland were explored and more than 7,000—these problems come out of Hurricane Hazel and other experiences having to do with the disturbance of our natural topography.

These then involve the seven divisions. Let me say a few other things in particular the State Board of Health has a relationship to, the postmortem medical-legal examination system. It is not a statewide—it is not yet a statewide system of medical examination, or medical-legal examination, a field you had so well discussed by Dr. Ford on Monday of this week.

Some 13 counties are in the system, have medical examiners, and these of course are those agents of government-investigated deaths. In cooperation with the system, there is in Chapel Hill a toxicology laboratory which serves as reference for them.

A final word now. Our greatest problems quite clearly now before us are those in Medicare. We are all in the field of revolution, whether this be in care, in cure, in prevention or rehabilitation. I find that we are working together; we have worked together closely in the past, and it is appreciated by those who work in the public health field that of course we can neither exist, you certainly cannot advance—we do so only at your pleasure and at your support.

So as a final word, let me say that our work when it is made successful, and when it's made effective, is made so by the staff who serve you, the policy-making Board who sets policy, and by the health profession always of the State, particularly the interested physicians of the State who make this the delightful place from a health standpoint that North Carolina is.

My last sentence would have to do with this: I thank the Board for the action it took today in making me Director and Burns Jones Assistant Director. (Applause)

And I thank those members of the audience who have supported me in the years that I have been in North Carolina, whether I have done epidemiology, or whether I have been at this post, in making it such an attractive place for me and my family; and as a final thank you, let me thank you for being so attentive to my words.

Thank you. (Applause)

DR. BAKER: I think we sometimes forget how large our State has grown, and the State Board of Health is a big organization, as you can guess from just a glimpse of what he tried to give you in a few moments. Without you people, it's nothing. We are fortunate in this State that the Medical Society does elect four people,

and we are fortunate thus far that the Governor has appointed one doctor.

I think you should know one thing. He has to appoint someone to represent the dairy industry, and we have to have somebody representing the veterinary profession, someone representing the dental profession, and someone representing pharmacology, which leaves him one appointment at large, and as evidenced by the last four appointments, the Governors of this state appreciated the medical profession. Sometimes the newspapers would make you think some of them don't, but they do.

We thank you for the Conjoint Session, and thank you for being here.

CHAIRMAN DUCK: We would like to make a presentation of the Aesculapius Award, Dr. Robert E. Miller, Chairman of the Committee on Scientific Exhibits.

DR. ROBERT E. MILLER: Ladies and gentlemen, members: Being Chairman of the Scientific Exhibits Committee reminds me of the man who made a remark as he was being carried out on a rail after being tarred and feathered. "Except for the honor, I'd rather walk," and this applies to the work that is done on this committee.

Approximately one thousand scientific exhibits have been reviewed and seen by members of this Committee and the staff. About 300 letters were written, and approximately 65 accepted; and of these 39 were chosen. So we have tried to maintain the high caliber of exhibits that has been carried on through the years, and I think this is evident downstairs.

There has been offered to the Medical Society of North Carolina, under the auspices of the Mead Johnson Laboratories, a monetary award and a plaque to be known as the Aesculapius Award. We have taken the liberty of dividing this into two parts, one in the field of clinical presentation, and one in the field of basic science presentation.

So without further ado, we would like to ask the winners to step forward.

(Presentation of awards.)

("Effect of Carbon Dioxide on Obstructed Cerebral Blood Flow," by Dr. Stephen A. Hegedus, et al; and "Factors Affecting the Osmotic Fragility of Normal and Bank Bloods," Dr. John Scudder.)

CHAIRMAN DUCK: The next thing on the program is the presentation of the AMA-ERF checks to Duke, the University of North Carolina and Bowman Gray Medical Schools.

I recognize to make this presentation the Chairman of the Committee on AMA-ERF, who is none other than Harry B. Underwood, M.D.

DR. HARRY B. UNDERWOOD: Are the representatives of the three medical schools here?

It is again my privilege, as it has been for the last three years—this is a committee that ought to be turned over a little. I think more people ought to know more about AMA-ERF and get acquainted with it a little bit more. I know that during the year, you get many brochures, etc., from the AMA. But again I'd like to point out that we are on the positive side of this Fund,

that is the Medical Schools in our State always get more than the doctors contribute to the fund.

I still think we ought to try to catch up with it. Every month I get a report of the money that is given, and sometimes it's \$300 or \$400, and sometimes it's a few thousand dollars, if it's around tax time, and I almost flipped my lid the other day when I picked up the report, and there was \$700,469. I thought certainly someone got fingers twisted on the machine to have that come out like that. However, it turned out that R. J. Reynolds Co. had given \$700,000.

One of the things we might not be familiar with in this Research Foundation is that there is a large amount of work being done on tobacco research, so this is where part of our money has come from.

This year the amounts that are scheduled to be given to the schools, Duke University, \$6,655.24; North Carolina School of Medicine, \$5,872.74; and Bowman Gray School of Medicine, Wake Forest College, \$5,195.44.

The next item, as you will note from your program, will be the recognition and presentation of the awards to Moore County, Wake County and Gaston County. This will be carried out by Dr. Lester A. Crowell.

DR. LESTER A. CROWELL, JR.: This is a pleasant task which I, as Chairman of the Committee on Scientific Awards, have the privilege of performing.

Each year three awards are given, in recognition of excellence of presentations at the preceding annual session of the State Society. This year, two awards will be given.

There was no one qualified for the Wake County Award.

For the Gaston County award, Dr. Carl N. Patterson of Durham. I am very much pleased, on behalf of the Committee on Scientific Awards, to present to you the Gaston County Audio-Visual Award in recognition of your splendid illustrated presentation before the Section on Ophthalmology and Otolaryngology in the May, 1965 Annual Session of the Society entitled "Physiological Septoplasty and Rhinoplasty."

The Committee found Dr. Patterson's presentation a clear and helpful treatise on the subject of interest to many people, both lay and professional. We commend Dr. Patterson on his expert description and handling of anatomical defects of the nose, a subject which has both functional and cosmetic importance for a very important part of the human anatomy.

Dr. Archibald Lipe Barringer made what to me was an especially pleasant presentation. I have known this physician for many years, and I consider him one of the most able physicians in the State. His paper "Urethritis in the Female" was presented before the Session on General Practice of Medicine during the May, 1965, annual session. In it, he describes the diagnosis and treatment of a condition often inadequately handled. He has shown that much can be done for these patients, and that treatment can be carried out in most cases in the physician's office.

Dr. Barringer, on behalf of the Committee on Scientific Awards, I hereby present to you this year's Moore County Award with the Committee's congratulations.

(Applause)

CHAIRMAN DUCK: Now we are indeed proud to have in our midst Dr. Thomas Hale, Jr., who graduated from Princeton with an A.B. Degree, and thence from Columbia with an LL.B., and went on to Vanderbilt University Medical School and received his M.D. from there.

As you will note in your program, Dr. Hale is the Administrative Vice President of the Albany Medical Center Hospital in Albany, New York. Dr. Hale!

DR. THOMAS HALE, JR.: I am very appreciative of the honor you have done me by asking me to come down here to speak to you this morning, and I am delighted to be back South again. Although I am a Northerner by birth, I did spend some of the best years of my life in Nashville, and I feel much more warmly toward the South than I do to the North. I think I can safely be called an adopted Southerner.

One of the most serious problems facing doctors and hospitals today is the shortage of nurses. For the past 10 years, I have been writing and talking about this shortage, and trying to pinpoint the causes which have produced it. It has been an up-hill battle because for many years the nurses themselves, through their two great national organizations, were not willing to admit that the shortage existed. Even today they still talk about maldistribution rather than shortage, and still accuse hospitals of not using their available nurse supply properly. However, these and other similar red herrings can no longer conceal the fact that there is a nationwide shortage of nurses, and it is getting worse all the time.

The shortage of nurses has been brought about because the relatively slight increase in supply during the past 15 or 20 years has been totally incapable of keeping up with the very rapid increase in demand. Hospitals have lost control of their nursing schools, the source of supply for the majority of all nurses. When hospitals controlled nursing education, they were very conscious of two overwhelming social imperatives—(1) to provide enough nurses to meet the country's needs, and (2) to graduate nurses who were competent to assume the responsibilities of a floor nurse in a hospital on the day they graduated. Nurse educators, however who now control all nursing schools, whether they be in hospitals or in colleges, have turned their backs on these two great objectives. This is the cause of most of our troubles today. To understand why this is so, it is necessary to review briefly the course of events in nursing education over the past 20 years.

First of all, a word about the nursing hierarchy. It consists of the National League for Nursing, the American Nurses' Association, and the individuals in each state who control the education and licensing of nurses within that state. In addition, there are the nurses who hold office in the HEW in Washington, including those who are advisors to the USPHS and the Surgeon General in the formulation of legislation and its implementation. And lastly, but far from least, are the individuals in control of collegiate nursing departments, and on the faculties of colleges and universities that have schools of nursing. Although this hierarchy is composed of different organizations, and quite a number of different

individuals, they speak with one voice and act as a unit in all matters relating to nursing education. No one who believes in hospital schools of nursing; no one who believes in the learn-by-doing method of educating nurses; no one who believes in the service ideal of nursing as opposed to the career philosophy; has held any position of influence in the nursing hierarchy for quite a number of years. It is necessary to understand this, because if one is in a war, it is important to know one's enemy. Let there be no mistake about it—we are in a war with respect to preserving hospital schools of nursing, and insuring that there are enough adequately trained nurses to meet the country's needs.

I should pause to say at this point that our 'enemies' in this war are very fine people. They are enemies in philosophy, not in personality, ability, or integrity. Nurse educators are women of fine character and good intention, but this does not make them always right. That they have been tragically wrong in certain vitally important respects for the past 20 years is abundantly proven by the situation which exists today with regard to the nursing shortage.

The idea of a college education for all nurses started back in the 1920's, was slowed down by the depression, and revived again during the 1940's. In 1948 Miss Esther Lucille Brown, a social anthropologist (not a nurse), made an extensive survey of nurse education under the auspices of the National Nursing Council, and wrote a book called "Nursing for the Future", which became the bible of the collegiately-minded nurse educators for a number of years. Early in the 1950's the concept of getting nurse education out from under hospitals and physicians and into "the stream of general education on the college campus" began to be hinted at, but was not yet openly advocated. The nurse educationists began to plan their strategy. In order to achieve their aims, it was necessary to identify and gain control over the power centers that govern the production of nurses, and just as a political revolutionary band lays plans to capture the radio stations, the newspapers and other communications media, the police, the public water supply, etc., when it wants to overthrow a government. The hospitals, with their diploma schools of nursing, were the long term target in this case.

Most nurse educationists publicly denied for many years that it was their intention to abolish hospital schools of nursing and move all nursing education onto the college campus. Recently, however, their spokesmen have become much bolder and more outspoken. This movement culminated openly in the resolution of your State Nurses Association in 1964, and more recently in the Position Paper of the American Nurses' Association last fall, which said as much in so many words. So there is no longer any question about the intentions of the nurse educationists, nor the goals they are seeking. It is interesting to note that it was the A.N.A. that published the Position Paper, thus allowing N.L.N. to continue its carefully nurtured stance of being in favor of all kinds of nursing schools, including the hospital schools. It is becoming increasingly clear the A.N.A. and N.L.N. have long been two arms of the

same body, with a single policy-making mechanism guiding and planning their destinies.

schools of nursing and the one-year practical nurse schools. This they have stated. This will leave only two-year associate degree programs and four-year baccalaureate programs. The two-year programs, which will provide an associate degree in nursing, will absorb the old hospital schools and the practical nurse schools. Graduates of these programs will be called nurse technicians. The term "Professional nurse" will be reserved for those girls who have graduated from a four-year baccalaureate program and obtained a degree.

I have always felt that this whole movement was based on false premises. This ambitious plan has nothing whatsoever to do with the welfare of the patient, but is primarily a means of increasing the status and prestige of nursing education, and incidentally of the nurse educationists. Had the welfare of the patient been the primary motivation, all efforts would have been devoted to permanently retaining the hospital schools as an essential element in the production of enough nurses, competently trained and educated, to meet the country's needs, the exact opposite has occurred.

Driven by their obsession to raise the status of nursing and nursing education, nurse educationists have lost sight of the fact that nursing education is part of a broad health spectrum that bears certain definite responsibilities to the COMMUNITY. No element in the total health pattern can be segregated from the whole, and permitted to operate in a vacuum, without dire results to the overall picture. In trying to carve nursing education out from its long established hospital-based niche and transfer it to be campus of educational institutions, nurse educationists have failed to step back and take a broad look at the end results which their policies have produced. Urged on by their compulsive desire to make nursing education a "professional discipline," which they wrongly believe can only be accomplished on the college campus, they have ignored the fact that this policy will almost certainly produce insufficient numbers of nurses, inadequately trained, and at a prohibitive cost.

One of the chief mechanisms in producing the nursing shortage has been the Accreditation Program of the National League for Nursing. I will describe in a moment how this happened. This program was initiated back in 1953 when the American Hospital Association made what I consider a serious mistake, and voted to sponsor the N.L.N.'s program. Not that accreditation is such a bad idea in itself—it is not. An Accreditation Program established by the American Hospital Association, in cooperation with the National League for Nursing, for example, could have been responsive to the needs and the wishes of its member hospitals, and might have prevented many of the excesses which have resulted from the N.L.N.'s program.

The N.L.N. established certain "standards" which hospitals with nursing schools were forced to meet in order to gain accreditation. The big mistake that N.L.N. made in its accreditation "standards" was to withdraw the student nurse from the bedside of the patient by radically cutting down the number of hours

of practice which would be permitted the school. In most hospital schools that have achieved, or are seeking accreditation, the hours of bedside practice have been so reduced that the student nurse has in most cases become merely an observer on the wards. Evening and night assignments have been cut back almost to zero, and the program has been enriched with many subjects which are admittedly interesting but are not directly pertinent to turning out a good nurse. In general, an academic atmosphere and attitude similar to that found on a college campus has been introduced. The service ideal of nursing has been down-graded and even sneered at. Students are not given responsibility for patient care, and consequently cannot be taught to feel such responsibility. At the time they graduate, they are in too many cases not capable of assuming the normal responsibilities of a general staff nurse on the floors of a hospital.

Two very serious problems have resulted from the withdrawal of the student from the patient's bedside. The first is that the student at the time of graduation does not know how to nurse patients, and the second is that the cost of the school has been radically increased. Let us take these up in order.

First, the question of competency. Two surveys of the competency of the graduates of two year associate degree programs in New York State have been made by the State Hospital Association in 1961 and 1965. These showed in general that most graduates of these community college nursing programs were not capable at the time of graduating of (1) giving safe bedside care, (2) giving treatments and medications, (3) team leading, or (4) taking charge of floors evenings, and nights. These are all things that formerly were expected of the graduate of a pre-accreditation three year hospital school. Our surveys in New York showed that it would take three to 12 months of close supervision for the graduates of the two-year programs to gain these competencies.

The graduates of most four year baccalaureate programs are little better qualified, if any. They, too, have eliminated bedside experience and practice during the nursing curriculum. An even more disturbing phenomenon is now occurring in hospital schools. Under pressure of accreditation demands, they are also abandoning bedside practice, and cutting down their curriculum from three years to 33, 30, 27, or even 24 months. Graduates of this kind of shortened hospital school program are little better prepared to nurse than are the graduates of the two-year and four-year baccalaureate programs. And they don't even get a degree.

Nurse educationists admit the deficiencies in the graduates of collegiate programs. This has not happened by chance but by design. The nurse educationists have adopted the concept that nursing education should not train students to be practitioners of nursing, but should concentrate on the theories back of nursing. Therefore, they say, it is not necessary for a student to waste time actually doing nursing during the collegiate part of her program. She can learn all she needs to learn about bedside nursing by being an observer for

short periods of time on the wards of some hospital.

The nurse educationists believe that once a girl has graduated, the hospital should employ her as a general staff nurse at a higher salary than diploma graduates, and then provide her with whatever is necessary in the way of closely supervised experience doing bedside nursing. What was formerly a part of the curriculum of the school of nursing, taught by the faculty of the school, and with the school accepting responsibility for the results, is now, according to the nurse educationists, the responsibility of any hospital which employs one of the graduate of the associate degree or baccalaureate programs.

So one of three things happens. If the new graduate does accept a position on a hospital staff, the hospital is forced to assign someone to watch her every move for a period of many months, in most cases, and to teach her all the nursing skills and arts that formerly were a basic part of the curriculum of nursing schools. Many hospitals, of course, do not have the personnel to provide this kind of supervision. Even when they do have personnel, they are put to considerable expense to give this experience. In addition, they have a serious morale problem when incompetent and unqualified graduates are paid the same salary as nurses who on graduation are capable of handling routine responsibilities on the floor without any close supervision.

The second thing that happens—and this happens frequently—is that the graduate of a degree program, because she herself realizes her inadequacies in nursing patients, does not seek a hospital position, but goes into some other area of nursing. This is particularly true of the baccalaureate graduates, who seldom enter hospital nursing, but more and more frequently obtain positions on the faculties of other nursing schools, either associate degree or baccalaureate programs. Not knowing how to nurse themselves, it is easy for them to accept the philosophy that the acquisition of skills in bedside nursing should not be taught in these schools.

Thirdly, if the graduate marries, as many of them soon do, she is lost to nursing during her child bearing period. But whereas many hospital school graduates return to nursing after their children are at a certain age, the degree graduate is much less likely to do so, because she fundamentally lacks confidence in her basic nursing skills and abilities.

Now this lack of competency is one of the two serious problems which I mentioned as being caused by the withdrawal of the student from the bedside of the patient. The other problem, now approaching a major disaster, is the tremendously increased costs of operating a nursing school. In the past, the costs of operating a school of nursing were balanced by the services rendered to patients by the matriculating students. In the old days no one did any exact calculations, but for years hospitals operated nursing schools on an apprenticeship basis, where the student paid little or nothing for her education, and the hospital broke even because of the services rendered to patients by the students. Two things happened at the same time, however, to change this picture. First, as the "standards" of nursing

schools were raised by the accreditation program, the costs skyrocketed, as would be expected. Concurrently, the services rendered by the students to patients began to diminish, and finally, as explained above, they have been almost entirely eliminated by the accreditation program. As tuition charges in hospital schools have mounted to meet rising expenses, recruitment has been adversely affected. The low tuition was formerly one of the big advantages which the average girl found in a hospital school, as compared with a collegiate program. Hospitals have been forced, however, either to raise their tuition until it hurt them competitively, or as an alternative, to keep their tuition low and subsidize their school. At first, many hospitals did hold tuition down, but as costs continued to rise, they were no longer able to continue a subsidization which began to amount to \$1500 to \$2000 dollars per student per year.

This would not have happened without the Accreditation Program. For example, the Albany Medical Center Hospital, of which I am Director, has a nursing school of 325 students. We still maintain a 44 hour week, combined theory and practice, and our students on graduation are competent bedside nurses. Many of them go on to earn a degree subsequently. The total net cost to one of our students for the three year program is \$245 dollars. The school has operated on a break even basis since it was established 11 years ago. We have not sought N.L.N. accreditation, because we feel that accreditation would result in our graduating incompetent nurses, and would also ruin our school financially. I cite this as a practical illustration of some of the generalities stated above.

As a result of rising costs and other factors, hospital schools are beginning to close in ever increasing numbers. The totals include both accredited and unaccredited schools. Between 1957 and October 1964, 106 diploma schools of nursing closed. Since October 14, 1964, 42 additional diploma schools have closed, or have indicated they are in the process of closing. Out of the present 88 hospital schools in New York State, 6 have indicated their intention of closing when their last class has been graduated. This will leave 82 schools out of the 94 that were in existence 2 years ago, a loss of 12 schools in this period of time.

Between 1958 and 1964, 67 new associate degree schools and 25 new baccalaureate schools have been established. During this period the admissions to all professional schools of nursing have increased by 6,404 or an average of 1,067 a year, and the number graduating has increased by 4,947, or an average of 824 a year.

However, the Surgeon General's report of two years ago stated that to meet the minimum number of nurses necessary for the country as a whole would require an increment of 3,000 additional graduates a year for the next 7 years (this was even before Medicare). It seems quite unlikely that this goal can be met.

No evidence has been adduced by the nurse educationists that the two-year and four-year collegiate nursing programs they are now promoting can produce enough nurses to meet all needs. To the best of my knowledge, no studies have been conducted by nurse

educationists, nor by anyone else, which would show this to be so. Nor have I heard of any studies to indicate that universities and colleges which do not now have nursing schools will be willing to establish them. It is the height of irresponsibility for nurse educationists to pursue a policy leading to the closing of hospital schools of nursing without first insuring that there will be enough degree schools in the same general area to make up the deficit. It is not sufficient to establish a lot of new schools in two-year and four-year colleges in a few states like New York, Texas, and California, for example, and hope that their graduates will fill vacant positions in hospitals in the rest of the country. These schools can't even supply enough nurses for their own states. Even if they could, it would be of little help to those states where diploma schools are closing, but few, if any, degree programs are opening.

I do not believe that the trend towards closing hospital schools of nursing and the shifting of nursing education from hospitals to the college campus is going to be reversed. We are faced, therefore, with a fait accompli produced in the past 20 years by the nurse educationists. If this trend continues, and I believe it will, then it behooves the medical profession and the hospital profession to devote their energies to salvaging what they can from the impending wreckage of the hospital schools.

I suggest the following program of action:

- 1) Urge every hospital which now operates a nursing school to continue its school. Many are currently on the verge of closing because they are so discouraged about financing, and about trying to meet unrealistic accreditation "standards" established by N.L.N. State and Federal fund may be necessary.

- 2) Urge hospitals with nursing schools not to cut down on the amount of bedside nursing in order to shorten their courses. To do so automatically increases the costs of the school, and at the same time produces inadequately trained nurses.

- 3) Urge every hospital with sufficient clinical material to start a new school of nursing if it does not already have one.

- 4) Urge colleges, junior colleges, and universities to establish nursing programs where there is available clinical material. This is a broad public responsibility that should be shared equally by public and private institutions.

- 5) Establish a state requirement that each graduate of a two-year or four-year collegiate program must have 12 months internship before she is licensed to practice nursing. This in turn would accomplish two vitally important purposes. First, it would insure that the public was protected by having nurses who were adequately trained to care for them when they are ill. Secondly, it would put a large dent in the nursing shortage practically overnight.

- 6) Discourage practical nurse schools from seeking accreditation from the National League for Nursing. Otherwise they will rapidly go the same way as the diploma schools have gone. The A.N.A. and many nurse education leaders have called for the abolition of practical nurses.

7) Pressure the National League for Nursing to relax its policy of weaning the student nurse away from the bedside.

8) Urge hospitals with schools of nursing to stop seeking accreditation from the National League for Nursing unless it changes its present policies.

9) Urge the American Hospital Association to establish an accreditation program for hospital schools of nursing, with the cooperation of the N.L.N. if possible, but without it if N.L.N. refuses.

10) Try to influence the N.L.N., and other student nurse recruiting agencies, to concentrate more on the service ideal of nursing, rather than emphasizing so strongly the career elements. This would attract into nursing more of those girls who are idealistically motivated, rather than girls who merely look on nursing as a stepping stone to more money and prestige.

11) Pressure State and Federal governmental agencies to provide financial aid directly to hospital schools of nursing for both construction and operation. Scholarships for individual students are fine, but the schools themselves also need basic support.

12) Help to abolish the discrimination in government grants and support which now favor schools accredited by the N.L.N.

13) Urge that appointment and advancement in the Veteran's Administration be made on the basis of merit, and not be limited by whether or not the nurse has graduated from a school accredited by the N.L.N., as is now the tendency.

14) Urge those colleges and universities which have nursing schools to give more realistic credits to qualified diploma school graduates for the work they have done during their training period. This credit generally has been dropped to one year or less, although not long ago many of these same colleges and universities did not hesitate to grant even as much as two full years of credit for the work done in the diploma school. Many are now granting no credit at all! The ability to obtain a degree after a reasonable period of postgraduate study is a strong incentive to recruitment in diploma schools, particularly where financial hardship exists, as it so often does.

15) Bring pressure to bear on the American Medical Association to appoint a nursing committee that is strongly motivated toward preserving hospital schools of nursing, and that is willing to stand up and be counted in its dealings with the nurse educationists.

16) Bring pressure to bear at the A.M.A. level on the American Hospital Association, which, in spite of some lip service, appears to have pretty well abandoned its hospital schools of nursing to their fate.

Great changes can be brought about overnight in this picture if A.M.A. and A.H.A. will only recognize clearly what has happened, and why it has happened. Too many individuals in both organizations have written off the hospital schools of nursing. Although a few years ago 98% of all nurses were graduated from hospital schools, now less than 75% are hospital school graduates, and the number is diminishing every year. It is not at all improbable that a snowball effect will soon develop

and overnight precipitate the rapid closing of countless more hospital schools.

There is still time to turn the tide, and the day can still be saved. But it will not happen by chance, or by letting things drift. The situation calls for keen analysis and courageous, cooperative action.

(Applause)

CHAIRMAN DUCK: Thank you, Dr. Hale, for a fine approach to a very critical problem.

(Recess)

(Dr. Paschal read his remarks at the opening of the Panel: The Heart, Cancer, Stroke Program and its Implications for North Carolina.)

(Dr. Paschal assumed the Chair.)

PRESIDENT PASCHAL: That completes my portion of the remarks. I want to turn now and we will proceed to discussion of further areas of this, and I think you will find it of interest to know about the application that we have made, which has been submitted, and what goes into this, and I'm going to ask Dean Anlyan if he will speak to this point.

DEAN WILLIAM G. ANLYAN: Thank you, President Paschal.

I think George has given us an admirable birds'-eye view of how our program is developing and has developed, and where we stand today. I for one hope that we will stop referring to this as the DeBakey Bill, because the DeBakey report really covered everything from sperm to worm, and the original bill really was only a very minor segment of the total report.

And finally, by the wonderful democratic process, as described by John Russell of the Markle Foundation, the original bill and the final act are completely different. So that I hope that we will refer to this as a regional medical program and not the DeBakey Program.

George has mentioned that the central core of our effort in the next two years will be planning activities. What sort of planning activities will go on under the directorship of Harvey Smith?

First we need to find out what are the relevant needs and resources of the health professions, not just physicians, but nurses and all the allied professions.

What are the educational program needs, the resources, the patterns of use? What are the illness and care patterns? This has to be effected much as Harvey Smith did in his mental health study, which is a classic.

Early in our deliberations we felt that continuing education and education should be one of the main themes of the program. We all know that with the tremendous paramedical information explosion, the rapid turnover of information—perhaps as rapidly as 50 per cent of the facts of today changing in five years—that continuing education certainly is going to be perhaps as important or more important than the four years in medical school.

With this in mind, the group began to address itself to the how do we mount a first-rate continuing educational program? The individual schools have for a long time had continuing education programs, and when Ike Manson and I became deans of our schools, we formed what was known as Project Ice, Inter-University Con-

tinuing Education Program, to see if we could coordinate these so as to avoid needless rivalry.

It became apparent to us at that time that this was a very expensive program, and that the consumer could not carry the cost of such a program. And it was about that time that this particular Act was enacted, and therefore it was a natural vehicle to enhance the continuing educational programs.

Initially, therefore, we hope to supplement what has already taken place, making better use of current television, live television telecasts, add video tape presentations to some of the two-way radio conferences, and initially hopefully get a mobile unit which can travel all over the State to record and to be of assistance in continuing education programs.

It is very important, as we see it, for the participation by the consumer; for a physician in hospital action to be a member of the passive audience receiving a continuing education program certainly would not benefit as much as if half of the program were devoted to a presentation of one of his patients and a two-day discussion of the problem of the day.

In addition, in the audio-visual portion of this program, we hope to develop 8 millimeter film cartridges that can be used for education of your patients and your paramedical personnel. For instance, how much time would you save, Amos, in not having to teach every individual diabetic patient, giving them the 15-20 minute spiel on how to use insulin? Of the patient who needs to be instructed in some other area?

So one of the purposes of this audio-visual program is to create time for the practicing physician, to save time for him, so that he can devote part of his day or part of his week to continuing education.

In the area of information transfer, and more particularly of libraries, we hope with this grant to be of more use to you in giving you any type of biographic information or reprint material that you may want.

Already the three schools in North Carolina and the two in Virginia are linked by a TWK system so that we can pool our resources, and what we don't have in one library can be secured from the others. We would hope that with this program we can make this service available to you at your office, or at your local community hospital, so that any bibliographic material that you may request, or reprints, can be handled initially by phone and subsequently within the next decade by a computer printout.

This does create some problems of copyright: being the editor of one Journal, I've just found out—it's a new journal—that we have a thousand subscribers now, but there are 11,000 xerox copies made of the articles there in every month. But we have some competent lawyers working on this problem.

Now with regard to the computerized hospital network system that is physician-oriented, again this is what we're looking at in this program, to create time for the practicing physician. How nice it would be to sift out from any of our libraries specifically what you want to read, and what you want to keep up with.

How nice it would be to have computerized hospital records, so that if you're at your office, you can

have a printout of what is in one of the hospitals in your community. How nice it would be to be able to share the same hospital record on your patient, whether the patient is in your office, at Duke or Chapel Hill, or at Bowman Gray.

How nice it would be, and how time-saving it would be to have the EEG laboratory studies all correlated by the computer. So that this is an example of what we're planning to do, perhaps not so much in the planning phase as in the operational phase, to see if, by computerization, and pooling, we can save the physician time and have the machine do some of the things that we're now doing as individuals.

And with the access to the triangle computer facility, which is one of the finest in the world, this will certainly be feasible.

Dr. Paschal has mentioned examples of some of the other feasibility studies that are in the offing, and at this time perhaps I should stop and have some of the other panelists comment on the program.

Thank you.

PRESIDENT PASCHAL: Thank you, Dr. Anlyan. Let's continue this. I hope there will be audience participation as we go along after we hear a little bit more about this.

I think you would be interested in knowing about the Grants Review mechanism about which Dr. Manson Meads is actually qualified to tell you. I didn't introduce him a while ago, but I would like to introduce him at this time, Dean of the Bowman Gray School of Medicine at Wake Forest.

Manson, would you discuss this part of it?

DR. MANSON MEADS: We thought it might be of some interest for you to know a little bit of what's going on in Washington right now as regards this program.

I was asked to serve on an Ad Hoc Committee to review the initial applications, and we met on April 26th, and I thought that maybe some feedback from that might be of interest to you.

As you have heard, this program is being administered by a new division of the National Institutes of Health, the Division of Regional Medical Programs. They have secured as head of this program, and with the title of Associate Director, NIH, Dr. Robert Marsden, who is Dean of the School of Medicine at the University of Mississippi. He is now going full-time to head this new division.

He is assembling, I think, a very strong staff which implies that the NIH is giving very, very serious consideration to this program and its development.

The regular review and approval mechanism will be similar to that NIH has used since its inception. The medical schools have worked with NIH since 1947. The mechanism which has been developed has also been one with which we have been reasonably satisfied. Its decision rests on approval of grants outside of the regular bureaucratic mechanism in Washington.

An advisory committee is appointed which reviews all grants. They make recommendations, and these are then submitted to a council, as defined by law. I think you would be interested to know—and this I believe por-

tends the future—that this Ad Hoc Committee had representatives of the AMA, Academy of General Practice, Hospital Administration, a Director of a regional hospital planning group, two deans, two professors of medicine, Director of a Cancer Institute, Chairman of a Department of Community Medicine, and a physician representing private practice.

It is a very heterogeneous group, but remarkable how in a period of two days this group certainly arrived at the common denominators of this program, as has been explained to you.

I think it is important to recognize that many of these grants that were turned in and are being developed came out of a really unclear atmosphere as to what was expected. Guidelines were received only about a month before the initial grants were turned in. I think this is good, because the 11 applications that were reviewed, all the way from Hawaii to Vermont, totalling about \$14 million, represented a wide spectrum, did represent local thinking, local planning, and not edicts that had come out from Washington as to how this program was to be carried out.

I think this is a good sign, because this is one of the fine things about this program, local planning and local development.

The problem was to separate planning from operational components of these 11 programs. Definitely, planning grants and planning studies will be funded during this initial go-round, and not anything which is definitely an operational phase of the program. This comes next, and an applicant may have approval of a planning grant, and within three to six months submit another application, a supplement, either to expand his planning study or to begin an operational program, any component thereof.

I think that the group was particularly concerned that any application that came in was not lopsided, that it was not an application which merely was going to support, say, continuing education in a region. This had to be a total look at the total care of and total resources, and total facilities of a region, and was there going to be a buildup of this total regional cooperative effort for the benefit of patient care in areas of heart disease, cancer and stroke, and related areas?

So that the breadth of the plan, the concentration on the categorical nature of this, because this is in the law, the strength of the regional cooperative arrangement—this couldn't be just a medical school getting together with one community hospital and trying to produce this program. It had to be a clearly defined region and broad cooperation.

There was concern that an advisory committee, when it was set up, was not still just a rubber stamp. This advisory committee would be actually a working committee that would approve and would oversee and guide the whole development of the program and evaluate as it went down in terms of objectives.

I think one other point was that they hoped that this would not concentrate just on physicians, that the impact would also be at the paramedical level.

Well, there's \$26 million in fiscal '66. They expect about 30 applications; and for fiscal '67, the President

has in his budget—and it has not been contested by Mr. Fogarty—so it looks like it's about it—it will be \$45 million. So you can see that the impact on the State of North Carolina is primarily getting ready to get into an operational phase. The impact on the physicians of this State is going to come over a period of time. I think this is wise. I think it is an unique opportunity to sit down with representatives of the various health professions and plan for a comprehensive approach to this. It's going to be very valuable, and this takes time if we're going to have an effective program.

Thank you.

PRESIDENT PASCHAL: Thank you, Manson.

Our application, as it was finally submitted, was one of a considerable number of pages, and we thought it was a very substantial document. I learned that the application that came from Texas weighed 146 pounds. I don't know what they included in that, but that was a very extensive thing.

I believe you would find it interesting to discuss something about the relationship of the medical centers to the demonstration hospitals, and I will ask Dr. Isaac Taylor to speak to this.

DR. ISAAC M. TAYLOR: Thank you, George.

I think one of the very interesting things about Public Law 89-239 is that it has provided an opportunity for medical schools and practicing physicians, and in our State the medical schools and the Medical Society, to get together in a very meaningful way.

One of the things that has bothered me about our State over the course of the last 15 years has been what I would observe to have been a drifting away from each other of the medical schools and the State Medical Society. This is an unnatural thing, certainly as far as the Medical School at the University of North Carolina is concerned.

The Medical Society played a major role in its establishment, and this is as it should be. For a variety of reasons, however, we have drifted apart, and one of the great and most exciting things to me about this present project is the fact that it brought the Medical Society and not only my medical school, but the other two medical schools in North Carolina, working together on a regular basis in the interest of medical care in our State; and I think that this is going to have very important benefits for all of us.

One of the reasons the medical educators and organized medicine can get together on this legislation is that both groups were scared to death when the bills were first introduced into Congress. The first we heard about it in medical schools was at a meeting of the Association of American Medical Colleges in Chicago, which occurred during, I guess it was, the winter of 1965, and concomitantly, there was occurring a meeting, a special meeting of the House of Delegates of the A.M.A. to talk about Medicare, the passage of which was incipient at the time.

Dr. Amos Johnson was quoted to me—and if I'm mistaken in relating this quote—he was quoted to me as saying that he was attending a meeting on the wrong bill, because the regional—the Heart Disease, Cancer and Stroke legislation had much more long-term im-

portance for the practice of medicine than Medicare.

At the same time as we say we medical school deans were hearing about the legislation for the first time, and many of us—I included—were very concerned that this represented a tour de force on the part of the Federal Government to impose upon medical schools—and I was looking at it from the medical school point of view at that time—the responsibility for undertaking the delivery of health care information effecting the patterns of the practice of medicine, the practice of referral of patients, in a fashion which I thought was fundamentally unsound, and which I knew my medical school was not prepared to embark upon with the limited resources which we had.

Well, as the legislation progressed through Congress, and particularly in the subcommittee of the House of Representatives, which was charged with its study and revision, major changes were made which make it a much easier bill to live with, and gives us the opportunity I believe to work together to make of the legislation what we want it to be. And when I say "we," I'm not talking as a medical school dean at this time. I'm talking of the entire medical community, medical schools, the Medical Society, the community hospitals, and practicing physicians.

I might say, parenthetically, that two of our Congressmen, Mr. Broyhill and Mr. Kornegay, were on the Congressional subcommittee which brought about the major improvement in the legislation, and I think they had an important part to play in that.

Our planning grant proposes that the three medical schools establish on a demonstration and feasibility study basis the relationship of three community hospitals, and these have been mentioned by George Paschal previously, a relationship between Duke and the Cabarrus Memorial Hospital at Concord; Bowman Gray and Mission Memorial here in Asheville, and my medical school and the Memorial Hospital in Greensboro.

These are in the nature of demonstration affiliations, and it's going to be part of the planning process to work out the relationship between these three hospitals and the medical schools to see what can be done.

I would like to take this opportunity to reiterate what Dr. Paschal has said, and that is that the initiative for the relationship between community hospitals and the medical school centers has got to come from the doctors who use the community hospitals. We do not think it possible for the medical school, any medical school, to go into any community and say to the doctors there "we want to affiliate with you and we're going to be a big help to you in the practice of medicine." This is absolutely beyond our desires and beyond our capability for many, many reasons which you will appreciate.

On the other hand, the provisions of this bill, if we get an operational grant, make it possible for the medical school to entertain proposals from groups of physicians working around the community hospital, or in a region of our state—make it possible for us to entertain proposals whereby if we can be of assistance, if the medical schools can be of assistance, we can work with you.

This will be made possible by making money available for this program. But I would like to make it perfectly clear that the initiative, by and large, needs to come from the local level and not from Winston-Salem or Durham, or Chapel Hill, nor will it come from the headquarters of the State Medical Society, I dare say.

As the program gets under way, as information about it is disseminated, we expect that groups of physicians will be interested, will see problems which they have in their communities, and will come to the medical centers with proposals for working together on those problems. I am hopeful that with this kind of local initiative we can really face problems straight on which must be bothering all of you as they bother us, as we see them in medical schools from our particular point of view, and get on with the solution of some of these things.

Now the organization which will spring from the planning studies gives us as physicians importantly the possibility of establishing mechanisms for dealing with a large variety of the Federal programs which are coming up in relation to health. These are assistance programs, primarily educational in nature, but they call for the participation of the medical profession in their implementation, and I would refer to the proposed legislation for educational systems, for allied professional groups, the poverty program from the Office of Economic Opportunity, the Appalachian program.

All of these programs have important implications for the practice of medicine, and for medical education, and we're going to be called upon to deal with them. We're going to be called upon to integrate these programs with the Heart Disease, Cancer and Stroke Program.

It seems to me that the Inter-School-Medical Society organization which we should be able to set up is going to be very useful to us in meeting our responsibilities as a profession with this plethora of new Federal programs.

PRESIDENT PASCHAL: Thank you very much, Dr. Taylor.

I think that we would be interested in knowing something about how the physician, how should the physician in the state be able to take advantage of this program; and one of our Medical Society representatives, Dr. Ladd Hamrick, will speak to this point.

DR. LADD W. HAMRICK: Thank you, Dr. Paschal.

Ladies and gentlemen, I will dwell primarily on the educational aspects of the program as far as practicing physicians are concerned, because from the standpoint of my interest in this program, this is the most practical aspect of it.

To briefly review some of the things that have been pointed out, and to look into the future somewhat, we envision a widespread two-way radio conference in which all of the medical schools will participate, which will have extreme flexibility as far as timing is concerned, so that the physician can pretty well take advantage of this at any time he desires.

The same information live-wire television broadcasts over the educational television system—the tap system

which has been mentioned is envisioned as covering the entire state, in which educational television tapes can be made by the medical centers, and this is already operational at all three medical schools. A system of dissemination of the state to be set up so that any physician, any hospital in the state can take advantage of these at any time through our so-called television truck that has been mentioned.

We envision that it will be possible to actually have conferences going on between a community hospital and a medical center, that tapes of patient presentations and discussions could be made, and then audio hookup for a few minutes after that for questions and discussion.

The television film packets that Dr. Anlyan mentioned I think have a very important role in this, in that many of these can be made for all varieties of patient instruction. They can also be broadened into physician instruction of paramedical personnel.

So that as the program is envisioned, we think there are a variety of ways in which the physician can keep abreast of current knowledge by very close communication with the centers through the tape mechanism and through direct communication.

Now this program is not designed specifically for physicians. We feel it would be of very little advantage to highly educate the physician and not have the individuals with whom he works be similarly instructed; and literally I think the program is envisioned as covering everybody in the hospital, from floor sweeper to administrator, and particularly to involve nurses and technicians, other paramedical personnel.

And as the program is envisioned in its future operation, we feel that all of these groups will be able to participate in this. In this way, of course better patient care, more efficient patient care, time-saving for the physician in that many of his more menial tasks can be turned over to some of the paramedical personnel.

The computer program which Dr. Anlyan has mentioned would seem to have far-reaching implications. He's mentioned the medical information repository. Many of you have been involved in setting up utilization committees. Dr. Meads tells me that his belief is you cannot set one of these up without a computer service. It is envisioned that this type of operation could be put into our computer program.

The instant bibliographic retrieval that is envisioned for the future where you can simply pick up the phone and say "give me the latest article on so-and-so," and it will be zipped off on a high speed printer and shoot the light right off our desk—this may be far in the future, but I don't think it's something that we should not look forward to.

This type of program, of course, will keep the physician abreast, make his ability to obtain knowledge much more rapid, and keep him in closer communication with the centers. It will enable him to better select patient referrals, better cooperate with the center in continuing care of the patient.

So in general, I think that this offers us a tremendous opportunity to bring down to a very short distance our lines of communication between the community hospital, the practicing physician, and the centers; and in

this way we envision a broad state network of medical care in which there are no hiatuses of communication, and in which both the physician can save time and be better equipped to take care of his practice, and in which the patient also will get better care because of this.

PRESIDENT PASCHAL: Thank you, Ladd.

Of course, going back to the local hospitals, I think we have an opportunity and really a responsibility to try to simplify and make more effective our system of record-keeping. To do this, I think we need to get rid of our kind of hodge-podge system of hospital numbers for our charts and patients, and I believe that we, as a Medical Society, in our local areas certainly, can work in our community hospitals in trying to change the pattern, the current pattern of hospital numbers for patients, and to make it something that would be uniform throughout the whole state.

In some areas, this has been changed so that every patient that comes into the hospital have his Social Security number. There are not very many people that don't have Social Security numbers, and it won't be long until everyone I think will. This might be one way that this can be done.

I would like to go on and ask Dr. Shackleford at this time to try to outline some of the various continuation education projects which might be proposed during the planning phase of this program. Bob, will you speak to that please?

DR. ROBERT H. SHACKLEFORD, JR.: Those of you who read the DeBakey Report—Dr. Anlyan suggests we not refer to it as such—but it was intimidated in this report that if the knowledge and skills presently available were applied by those of us who have the responsibility of caring for patients, that we could do away with heart disease, cancer and stroke. This is somewhat facetious, and I'm sure that we don't really believe that this was implied in the report.

But in any event certainly there is a great gap, or too large a gap between the development of techniques, the development of changing patterns of patient care, and the application of these patterns in the day-to-day care of the patient in Mt. Olive or Garland, or Salisbury, or Charlotte, or wherever this may happen to be.

The key to improving this is continuing education, both physician oriented, and paramedically oriented areas, because many of the new techniques and the new procedures today are not possible with physicians only. They are possible only when physicians are able to work with teams of highly skilled paramedical people.

Our planning group sees education as one of its earliest goals, and we indicated we wanted all the fields of education.

There are many techniques, and we can see that the optimal technique for physician education provides immediate personal consultation to assist with the puzzling medical problem, but this is not attainable on a wide scale. And the various audio-visual programs that have been referred to previously are being proposed as an intermediate step in helping to give us a little more intermediate consultation, to help us talk about problem cases with various experts in the field, to talk

about the problems that occur not with the theoretical patient, or not with the patient in the medical center, but many times with a patient that you or I happen to have under treatment at this particular time.

The various types of film cartridges to be used by other than nursing groups; the audio-visual program which we have indicated is also included in this; the cooperative arrangements between the various hospitals certainly will provide many opportunities for continuing education, conferences, and consultations, to be held at the hospital, and involved where you can talk with these men about your own particular patients.

Bowman Gray proposes a physician traineeship, and this is a program in which their present teaching rounds, or present teaching conferences that are used to teach medical students and their house officer—these conferences would be arranged so that the physician in practice could come for a series of weeks and participate in these conferences.

We plan to make application in our grant for funds to pay physicians a per diem which would cover some of his overhead during the time that he spent in involving himself in these studies. We feel that this would encourage more people to do this.

Just an example: At Bowman Gray on Tuesdays, at the present time, at 8 to 9 o'clock, they have a neurology panel, from 9:30 to 12 noon they have neurology teaching clinic with referred patients. From 1 to 2, they have a neurology conference, which is both gross and microscopic pathology in neurology, and then from 4 to 5 they have neurology, neuro-surgery, neuro-ophthalmology, a clinic conference.

They propose to add to this from 2 to 3, a neurology conference for the visiting trainees to present material and discuss problems.

Therefore, with the addition of one-hour courses, a physician could attend these session on a weekly basis for a period of six months, or whatever length of time were to be determined, and get a great deal of intense training in neurology, and certainly this would have wide implication in his educational opportunities in heart, cancer—in stroke in particular—and the various neurological disorders that go along with this.

There is a wide possibility in many areas for continuing education, and for those of us in practice who sit on this Executive Committee, we feel that there is an excellent opportunity to provide each of you with many excellent continuing educational opportunity.

PRESIDENT PASCHAL: Thank you, Robert. We're about to run out of time. I'm afraid that I'm guilty of stealing some of Dr. Poteat's subject matter and denied him the right to express all of those things, but he does have a couple of minutes, and let him talk to you at this time.

DR. HUBERT M. POTEAT, JR.: That was about the most ungracious introduction I ever had.

Mr. Chairman, the hour cometh that we really should be through with this, and I shall not detain you but a moment.

I think most of us are quite skeptical and apprehensive of any edict that emanates from the palaces of the North Bank of the Potomac. When you add to that a

catalyst of a surgeon who operates in an astrodom so that everybody can see him, you have an almost untenable situation.

When George asked me to represent the Medical Society on this committee, I had considerable misgivings. However, I soon learned that the original concept of the so-called DeBakey bill had been modified so that it did not even resemble its original intent.

These three distinguished gentlemen who serve as the Deans of our medical schools were reluctant to say it. I'm not. They are the ones primarily who were responsible for having this bill modified to the degree that we can live with it. They did this through our Congressmen, and we are indeed in their debt.

It has been a source of a great deal of pride to me to see the fine relationship which exists between our three medical schools. They leave their rivalries where they belong, on the football field and basketball court. Their relationship to those of us who are in private practice in community hospitals is on a first-name basis. That puts North Carolina in a very unique position.

There is no reason that this whole program won't accrue to the benefit of our patients, and after all that's what we're interested in. This is an educational program.

Chub Seawell said an intellectual was an egghead who had had more education than his intelligence can tolerate. I hope we don't get overeducated.

PRESIDENT PASCHAL: Thank you, Hubert. It appears that we're really out of time. We might have time for one or two questions.

QUESTION: When a community hospital makes an application for participation, do they have to ask for certain affiliation with either one of the schools?

DR. TAYLOR: I did refer to this. I think the answer to this is in the future to determine and will be one of the things which the planning group will have to examine. These exact mechanisms are not clear. As of the present moment, a community hospital, a group of physicians around the community hospital, who want to establish an affiliation should address, I think, one of the three medical schools.

I would like to expand my earlier remarks a moment about this, because I suspect that the practicing physicians in this state, in the community hospitals, are going to be disappointed at the foot dragging which the medical schools do in this business, because if the ivory tower is white in color, it's white in color because sweat is relatively transparent, and there's a good deal of work going on in the ivory towers now. Certainly we think so.

And the faculties of medical schools are loath to undertake marked extension of their responsibilities until we can get some assistance. So I want to say that it's likely there that many communities will be cross with us because we just don't leap to the breach at the slightest suggestion.

Now these affiliations, you will find too, are not easy to work out, because when you start getting a group of doctors and a group of academic physicians together, the differences very soon, in points of view which are

real, come to the surface, and it takes time to negotiate these points.

For the present, however, it seems to me that hospitals which are interested in exploring affiliations ought to approach one of the medical schools directly.

PRESIDENT PASCHAL: Thank you very much.

DR. SHACKLEFORD: I think it might help to point out that the three proposed relationships that are going on are part of our planning program, and these represent feasibility studies to determine how feasible it is for a medical school to affiliate with a community hospital. And a great deal of what is done in the future will depend on our evaluation of these present feasibility studies, and so we will know how much will it cost? How much manpower will it take to maintain a certain type of relationship with a community hospital?

A lot of this has to be worked out, and the exact mechanisms will depend to a large extent on the continuing study of the proposed relationships that are going to exist in the planning phase of our program.

DR. HAMRICK: I think it might be worthwhile to point out also that this is envisioned as an extremely flexible situation, and there will be many opportunities to participate in the program without having an iron-clad relationship with one of the schools. There are many facets of this program which will be available on a broad coverage basis, so that you may participate at almost any level you want to. And if a community hospital desires to have a more firm relationship, then this may be developed. But I believe as we envision the program, there is a level at which the schools co-operate in producing various educational programs, that any physician can take advantage of without having to establish one of these firm relationships.

Now if you want more, why then you have to establish such.

PRESIDENT PASCHAL: I would like to re-emphasize that the whole bill is predicated, or the whole Act is predicated on local planning, and this calls for leadership at the local level, and this is where the individual files, I think, and the Medical Societies locally can make a very substantial contribution.

DR. BEDDINGFIELD: Do we have time for one comment and one question, Dr. Paschal?

I would like to say this in credit to the deans. Certainly organized medicine was very wary and obviously hostile to the Heart, Cancer and Stroke program as it was first introduced. We'd just been clobbered by you know what at the time, and this had big implications, and North Carolina was strategically an important state, because we were the only state that had two Congressmen who were members of the House Interstate and Foreign Commerce Committee considering this legislation.

So the deans of the three North Carolina schools were important in approaching this committee. And in credit to them I would like to say that before they expressed themselves to Washington, they did communicate with the State Medical Society and sought our ideas, and worked very fine with us at all times all along the line.

Now the question, and I will direct this to Dr. Meads.

Some of the proponents of the original bill felt that what happened in committee was an emasculation. I have seen that word. Other people speak of it as an improvement and a refinement in the bill. I wonder if you sense in your dealings at NIH that this was indeed an emasculation, and I wonder if you sense that there will be soon any efforts to amend the legislation more in the direction of the regional bill.

DR. MEADS: Certainly the discussion we had on the 26th and 27th of April, Ed, I saw none of that. I saw an attempt in fact to be very careful that anything that was done was within the confines of the bill as it was amended, and the present bill we have.

We can't reject the future, but we all have to be alert to any effort. There is this other group, and we have to be constantly alert to this.

But certainly the group that is now in charge of the operation of this new division is strictly interested in the intent of the bill, as it is now written, and there was no indication that they wanted to make any new amendments.

DR. CROWELL: Mr. Chairman, could I ask one question?

Do I understand that the medical schools will be responsible for the collection and correlation and the preparation of the material that will be distributed over this radio and television network?

DR. ANLYAN: In the planning phase, yes. I think we would have the staff among the three schools, particularly with the mobile unit, so that the staff could move down to any community hospital or clinic, and initiate or tape a program at that point. So that we would provide the central staff; that's right.

DR. MEADS: Could I say one word on that? One phase of the planning grant is an individual will be responsible for collecting data from the physicians of the state as to what they want in terms of continual education. I think this is one thing that we at the medical schools have no idea of, what you want and what you need.

So that during the planning phase, and we hope this is going to be a project that has the particular attention of the State Medical Society and sponsorship—we will have staff who will be able to get to your offices, to county medical societies, to try to find out what the physicians of this state want in terms of continuing education.

PRESIDENT PASCHAL: Thank you very much. I regret that the time is over. I want to thank the members of the panel for their participation. The Medical Society has indicated its interests in this by authorizing the appointment of our representatives to this planning group, and we will hear more about this program as time goes along, and we will continue to be represented adequately at all levels of the planning phase and later in the operational phase.

Thank you very much. I am grateful to all of you for listening.

(Dr. Duck resumed the Chair.)

CHAIRMAN DUCK: We congratulate the panel for this very intellectual approach today.

For your interest, you might want to know how many people are registered here. We have registered a total of 1,059 person at this 112th Annual Meeting. Of this group, we have 546 M.D.'s, and we have 114 medical students. The rest are exhibitors and other related personnel.

At this time we come to the election of some officers. There are, as you will notice on your program, two vacancies on the Editorial Board of the North Carolina Medical Journal. These positions have been vacated by the expiration of the terms on the following doctors, Dr. Robert Prichard and Dr. John B. Graham.

Do I hear a motion at this time for nominations for the Editorial Board of the Medical Society Journal?

DR. STYRON: Mr. Chairman, Dr. R. A. Ross was nominated by the Editorial Board for the interim term, and I should now like to nominate Dr. R. A. Ross for a four-year term, and also Dr. Robert Prichard, the Editor of the Journal, for a four-year term.

CHAIRMAN DUCK: Thank you, Dr. Styron. I might point out that Dr. J. B. Graham resigned from the Board, and his term expired also. But Dr. Ross had served in the interim, as Dr. Styron pointed out, and these nominations are on the floor.

Are there other nominations for these Board positions?

(A motion was made that nominations be closed, which was duly seconded.)

All in favor of the motion that the nominations for the Editorial Board be closed, and that Dr. Robert Prichard and Dr. Robert A. Ross be elected by acclamation, let it be known by saying "aye"; opposed by like sign.

The motion is carried, and they are elected.

And now we have further vacancies which exist on the North Carolina Board of Medical Examiners, and they exist because of the expiration of terms in each instance by Dr. Joe Combs and Lee Large. The terms of these gentlemen have expired this year, as of this day, and we are to replace them.

Do I hear a motion for nominations for the post of medical examiner?

A MEMBER: I would like to place in nomination the name of J. J. Combs.

A MEMBER: I would like to place in nomination the name of Dr. Lee Large for the term for the next six years.

CHAIRMAN DUCK: Dr. Joe Combs and Dr. Lee Large have been nominated from the floor to resume their original positions on the Board of Medical Examiners.

DR. BENTON: I move that nominations be closed.

(The motion was seconded.)

CHAIRMAN DUCK: It has been moved that the nominations be closed, which has been duly seconded. Do I hear any discussion?

(The question was called.)

All in favor of these gentlemen being replaced on the Board of Medical Examiners let it be known by saying "aye"; all opposed by a like sign.

The motion is carried, and we have the vacancies filled, and that dispenses with the elections for the day, but I will bring back to the podium Dr. George W. Paschal, Jr., who will proceed the installation of officers for the coming year.

(Installation of officers.)

CHAIRMAN DUCK: At this time, it gives me a great deal of pleasure indeed to introduce to you your newly installed President for the year 1966-67 in the North Carolina State Medical Society, a man who has given a lot of time and a lot of effort toward the goings on and toward the interest of the State of North Carolina as it pertains to medicine.

I present to you at this time the President of the Medical Society of the State of North Carolina, Dr. Frank Jones of Newton.

(The delegates rose and applauded.)

(Dr. Jones read a prepared manuscript which will appear in the N. C. Medical Journal.)

Presentation of prizes.)

(The meeting adjourned at twelve o'clock noon.)

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EARLY HISTORY OF THE MEDICAL SOCIETY OF THE STATE OF NORTH CAROLINA FROM ORGANIZATION TO 1804

Date	Place	President	Vice Presidents	Corresponding Secretary	Secretary	Recording Secretary	Treasurer	Censors
Dec. 17, 1799 or April 16, 1800	Raleigh	Richard Fenner	Nathaniel Loomis John Claiborne	Calvin Jones		Wm. B. Hill	Cargill Massenburg	Sterling Wheaton James Webb Jas. John Pasteur Jason Hand
Dec 1, 1800	Raleigh	Richard Fenner			Sterling Wheaton			
Dec 1, 1801	Raleigh	John C. Osborne	Thomas Mitchell Richard Fenner	Calvin Jones	Sterling Wheaton		Cargill Massenburg	James Webb John Sibley
1802	Raleigh	John C. Osborne		Calvin Jones				
1803	Raleigh	John C. Osborne		Calvin Jones				
1804	Raleigh	John C. Osborne		Calvin Jones				

HISTORY OF THE MEDICAL SOCIETY OF THE STATE OF NORTH CAROLINA FROM 1849 TO 1965

*Missing Data Not to be Found in Record

Date	Place of Meeting	Number in Attendance	President	Vice Presidents*	Secretary	Treasurer*	Members on Roll*	Honorary Members*	Honorary Fellows*
1849	Raleigh	25	F. J. Hall		W. H. McKee		25		
1 1850	Raleigh	21	E. Strudwick	F. J. Haywood, C. E. Johnson, J. E. Williamsor, W. G. Thomas	W. H. McKee	W. G. Hill	38	0	
2 1851	Raleigh	23	E. Strudwick	C. E. Johnson	W. H. McKee	W. G. Hill	46	0	
3 1852	Wilmington	38	J. E. Williamson	Thomas N. Cameron, William G. Hill, Johnston B. Jones, N. J. Pittman	E. B. Haywood	J. J. W. Tucker	72	12	
4 1853	Fayetteville	24	J. E. Williamson	William G. Hill, Johnston B. Jones, J. B. G. Myers, N. J. Pittman	W. W. Harris	Daniel Dupree	80	14	
5 1854	Raleigh	37	J. H. Dickson	N. J. Pittman, J. B. G. Myers, J. Graham Tull, A. D. McLean	S. S. Satchwell	Daniel Dupree	84	17	
6 1855	Salisbury	23	J. H. Dickson	J. Graham Tull, Owen Hadley, A. D. McLean, Hugh Kelly	S. S. Satchwell	J. B. Dunn	96	18	
7 1856	Raleigh	35	C. E. Johnson	Marcellus Whitehead, F. R. Gibson, Johnston B. Jones, O. F. Manson	S. S. Satchwell	J. B. Dunn	101	22	
8 1857	Edenton	25	C. E. Johnson	Marcellus Whitehead, O. F. Manson, H. W. Faison, E. T. Gibson	W. G. Thomas	J. B. Dunn	113	16	
9 1858	New Bern	69	W. H. McKee	Edward Warren, C. W. Graham, Caleb Winslow, A. B. Pierce	W. G. Thomas	J. B. Dunn	172	18	
10 1859	Statesville	81	W. H. McKee	James G. Ramsey, P. E. Hines, J. R. Mercer, W. T. Howard	W. G. Thomas	C. W. Graham			
11 1860	Washington	64	N. J. Pittman	P. T. Henry, R. H. Winborne, M. Whitehead, T. S. Leach	W. G. Thomas	C. W. Graham	233	18	
12 1861	Morganton	23	N. J. Pittman	J. J. Summerell, C. T. Murphy, G. W. Hodges, W. A. B. Norcom	W. G. Thomas	C. W. Graham	244	18	
13 1866	Raleigh	20	J. J. Summerell	E. Burke Haywood, P. H. Winborne, W. L. Barrow, J. W. Jones	W. G. Thomas	C. W. Graham			
14 1867	Tarboro	41	W. G. Thomas		S. S. Satchwell	C. W. Graham	288	11	
15 1868	Warrenton	27	S. S. Satchwell	Hugh Kelly, George A. Foote, Charles J. O'Hagan, J. H. Baker	Thomas F. Wood	J. W. Jones			
16 1869	Salisbury	36	F. B. Haywood	Thomas F. Wilson, A. B. Pierce, C. T. Murphy, M. A. Locke	Thomas F. Wood	J. W. Jones			
17 1870	Wilmington	38	C. I. O'Hagan	E. A. Anderson, F. N. Luckey, W. R. Sharpe, R. L. Payne	Thomas F. Wood	J. W. Jones			
18 1871	Raleigh	35	Hugh Kelley	D. N. Patterson, R. C. Pearson, J. B. Seavy, G. L. Kirby	Thomas F. Wood	J. W. Jones			
19 1872	New Bern	34	W. G. Hill	H. W. Faison, R. I. Hicks, G. H. Macon, W. A. B. Norcom	James McKee	J. W. Jones			
20 1873	Statesville	43	M. Whitehead	W. T. Ennett, William Little, Charles Duffy, P. T. Jermain	James McKee	H. T. Bahnson			
21 1874	Charlotte	56	W. A. B. Norcom	J. B. Jones, R. F. Lewis, C. G. Cox, J. I. Knight	James McKee	H. T. Bahnson			
22 1875	Wilson	60	J. W. Jones	Walker Dehnam, J. A. Gibson, William Little, D. N. Patterson	James McKee	H. T. Bahnson	148	5	
23 1876	Fayetteville	33	Peter E. Hines	J. H. Baker, G. G. Smith, T. D. Haigh, J. K. Hall	James McKee	H. T. Bahnson	157	4	
24 1877	Salem	42	George A. Foote	J. K. Hall, B. W. Robinson, A. Holmes, A. A. Hill	James McKee	A. G. Carr	177	4	
25 1878	Goldsboro	79	R. L. Payne	E. M. Rountree, Richard Anderson, S. B. Flowers, L. A. Stith	L. J. Picot	A. G. Carr	194	6	
26 1879	Greensboro	109	Chas. Duffy, Jr.	J. A. Gibson, Willis Alston, James McKee, A. A. Hill	L. J. Picot	A. G. Carr	198	6	
27 1880	Wilmington	105	J. F. Shafer	J. K. Hall, W. C. McDuffie, W. R. Wilson, R. F. Lewis	L. J. Picot	A. G. Carr	225	6	
28 1881	Asheville	92	R. B. Haywood	J. E. McRee, W. H. Lilly, R. H. Speight, W. I. H. Bellamy	L. J. Picot	A. G. Carr	254	6	
29 1882	Concord	65	Thos. F. Wood	T. J. Moore, D. J. Cain, S. E. Evans, John McDonald	L. J. Picot	A. G. Carr	297	7	
30 1883	Tarboro	112	J. K. Hall	A. W. Knox, J. M. Hadley, E. S. Foster, John Whitehead	L. J. Picot	A. G. Carr	310	7	
31 1884	Raleigh	112	A. B. Pierce	F. W. Potter, G. W. Graham, R. Dillard, G. W. Long	L. J. Picot	A. G. Carr	348	7	
32 1885	Durham	173	W. C. McDuffie	James McKee, T. E. Anderson, W. H. Whitehead, A. G. Carr	W. C. Murphy	R. L. Payne, Jr.	424	6	

HISTORY OF THE MEDICAL SOCIETY OF THE STATE OF NORTH CAROLINA FROM 1849 TO 1966—Continued

*Missing Data Not to be Found in Record

Date	Place of Meeting	Number in Attendance	President	Vice Presidents	Secretary	Treasurer	Members on Roll July 15	Honorary Members	Honorary Fellows*
33 1886	New Bern.....	113	Joseph Graham.....	H. T. Bahnson, L. J. Picot, J. L. McMillan, W. W. Faison.....	J. M. Baker.....	R. L. Payne, Jr.....	438	7	-----
34 1887	Charlotte.....	112	H. T. Bahnson.....	G. G. Smith, J. L. Nicholson, C. M. Van Poole, H. B. Ferguson.....	J. M. Baker.....	R. L. Payne, Jr.....	452	7	-----
35 1888	Fayetteville.....	133	T. D. Haigh.....	W. T. Ennett, J. A. Dunn, T. E. Anderson.....	J. M. Baker.....	C. M. Van Poole.....	396	6	-----
36 1889	Elizabeth City.....	50	W. T. Ennett.....	W. J. Jones, S. W. Stevenson, G. W. Long.....	J. M. Baker.....	C. M. Van Poole.....	410	6	-----
37 1890	Oxford.....	160	G. G. Thomas.....	R. L. Payne, Jr., Richard Dillard, S. D. Booth.....	J. M. Hays.....	C. M. Van Poole.....	414	6	-----
38 1891	Asheville.....	135	R. H. Lewis.....	S. W. Battle, J. L. Nicholson, W. H. Lilly.....	J. M. Hays.....	C. M. Van Poole.....	422	6	-----
39 1892	Wilmington.....	162	W. T. Cheatham.....	T. S. Burbank, J. W. Long, W. H. H. Cobb, W. D. Hilliard.....	J. M. Hays.....	C. M. Van Poole.....	431	6	-----
40 1893	Raleigh.....	221	J. W. McNeill.....	W. C. Galloway, H. H. Harris, J. M. Hadley, Thomas Hill.....	R. D. Jewett.....	M. P. Perry.....	447	5	3
41 1894	Greensboro.....	166	W. H. H. Cobb.....	J. A. Hoiges, R. W. Tate, Willis Alston, M. H. Fletcher.....	R. D. Jewett.....	M. P. Perry.....	454	5	3
42 1895	Goldsboro.....	.....	J. H. Tucker.....	J. Howell Way, W. H. Harrell, O. McMullan, C. A. Misenheimer.....	R. D. Jewett.....	M. P. Perry.....	436	7	3
43 1896	Winston-Salem.....	158	R. L. Payne.....	S. D. Booth, J. P. Mugroe, J. A. Burroughs, J. E. Grimsley.....	R. D. Jewett.....	M. P. Perry.....	452	7	3
44 1897	Morehead City.....	103	P. L. Murphy.....	J. C. Walton, A. A. Kent, M. R. Adams, B. L. Long.....	R. D. Jewett.....	M. P. Perry.....	406	6	3
45 1898	Charlotte.....	.....	Francis Duffy.....	E. C. Register, A. T. Cotton, J. H. B. Knight, F. H. Russell.....	R. D. Jewett.....	M. P. Perry.....	437	6	21
46 1899	Asheville.....	152	L. J. Poot.....	I. W. Faison, J. W. White, H. H. Dodson, W. C. Brownson.....	Geo. W. Presley.....	G. T. Sikes.....	480	6	16
47 1900	Tarboro.....	115	George W. Long.....	C. M. Van Poole, James M. Parrott, T. B. Williams, W. D. Hilliard.....	Geo. W. Presley.....	G. T. Sikes.....	482	6	21
48 1901	Durham.....	186	Julian M. Baker.....	M. H. Fletcher, C. A. Julian, D. A. Stanton, E. M. Summerell.....	Geo. W. Presley.....	G. T. Sikes.....	515	5	18
49 1902	Wilmington.....	147	Robert S. Young.....	A. G. Carr, E. D. Dixon-Carroll, I. M. Taylor, J. M. Parrott.....	Geo. W. Presley.....	G. T. Sikes.....	546	5	20
50 1903	Hot Springs.....	155	A. W. Knox.....	E. G. Moore, C. A. Julian, W. W. McKenzie, J. L. Nicholson.....	J. Howell Way.....	G. T. Sikes.....	530	6	19
51 1904	Raleigh.....	326	H. B. Weaver.....	John Hey Williams, John C. Rodman, S. F. Pfohl.....	J. Howell Way.....	G. T. Sikes.....	1,033	8	17
52 1905	Greensboro.....	361	David T. Tayloe.....	C. A. Julian, John T. Burrus, I. W. Faison.....	J. Howell Way.....	G. T. Sikes.....	1,175	8	17
53 1906	Charlotte.....	406	E. C. Register.....	L. B. M. Brayer, W. H. Cobb, Jr., W. O. Spencer.....	J. Howell Way.....	G. T. Sikes.....	1,234	8	16
54 1907	Morehead City.....	217	Samuel D. Booth.....	C. M. Strong, J. E. McLaughlin, W. F. Hargrove.....	David A. Stanton.....	H. McK. Tucker.....	888	7	16
55 1908	Winston-Salem.....	372	J. Howell Way.....	J. E. Stokes, J. A. Turner, W. H. Dixon.....	David A. Stanton.....	H. McK. Tucker.....	998	7	28
56 1909	Asheville.....	337	J. F. Highsmith.....	C. M. Van Poole, D. A. Garrison, D. O. Dees.....	David A. Stanton.....	H. McK. Tucker.....	1,067	7	25
57 1910	Wrightsville Beach.....	276	J. A. Burroughs.....	E. J. Wood, John Q. Myers, L. D. Wharton.....	David A. Stanton.....	H. D. Walker.....	1,080	8	35
58 1911	Charlotte.....	412	E. J. Wood.....	C. M. Van Poole.....	David A. Stanton.....	H. D. Walker.....	880	8	45
59 1912	Hendersonville.....	296	C. M. Van Poole.....	J. V. McGougan, W. E. Warrea, L. N. Glenn.....	David A. Stanton.....	H. D. Walker.....	950	8	44
60 1913	Morehead City.....	232	A. A. Kent.....	J. P. Monroe, W. P. Horton, J. G. Murphy.....	John A. Ferrell.....	H. D. Walker.....	1,133	8	40
61 1914	Raleigh.....	431	J. P. Munroe.....	F. R. Harris, E. S. Bullock, L. B. Morse.....	John A. Ferrell.....	H. D. Walker.....	1,228	8	47
62 1915	Greensboro.....	443	J. M. Parrott.....	E. T. Dickinson, J. T. J. Battle, D. E. Sevier.....	John A. Ferrell.....	H. D. Walker.....	1,221	9	68
63 1916	Durham.....	406	L. B. McBrayer.....	J. J. Phillips, C. W. Moseley, S. M. Crowell.....	Benj. K. Hays.....	W. M. Jones.....	1,228	10	79
64 1917	Asheville.....	280	M. H. Fletcher.....	J. L. Nicholson, L. N. Glenn, W. H. Hardison.....	Benj. K. Hays.....	W. M. Jones.....	1,271	11	81
65 1918	Pinehurst.....	291	Charles O'H Laughinghouse.....	D. J. Hill, J. L. Spruill, J. H. Shuford.....	Benj. K. Hays.....	W. M. Jones.....	1,087	11	81
66 1919	Pinehurst.....	335	I. W. Faison.....	Wm. deB. MacNider, Jos. B. Greene, Bea F. Royal.....	Sec.-Treas. Benj. K. Hays.....	Acting Sec.-Treas. L. B. McBrayer.....	1,306	11	100
67 1920	Charlotte.....	479	Cyrus Thompson.....	J. W. Halford, T. W. Davis, A. McNeill, Blair.....	Benj. K. Hays.....	L. B. McBrayer.....	1,497	12	100
68 1921	Pinehurst.....	404	C. V. Reynolds.....	H. D. Walker, F. Stanley Whitaker, Thos. I. Fox.....	Benj. K. Hays.....	L. B. McBrayer.....	1,491	12	93
69 1922	Winston-Salem.....	507	T. E. Anderson.....	C. S. Lawrence, W. H. Ward, J. M. Manning.....	Sec.-Treas. L. B. McBrayer.....	L. B. McBrayer.....	1,571	12	100
70 1923	Asheville.....	356	H. A. Royster.....	W. T. Parrott, B. C. Nalle, J. R. McCracken.....	L. B. McBrayer.....	L. B. McBrayer.....	1,592	9	101
71 1924	Raleigh.....	525	J. W. Long.....	F. M. Hanes, T. C. Johnson, B. L. Long.....	L. B. McBrayer.....	L. B. McBrayer.....	1,604	9	106
72 1925	Pinehurst.....	550	J. V. McGougan.....	J. L. Spruill, Eugene B. Glenn, D. A. Garrison.....	L. B. McBrayer.....	L. B. McBrayer.....	1,657	10	116
73 1926	Wrightsville Beach.....	445	Albert Anderson.....	W. L. Dunn, A. E. Bell, K. G. Averitt.....	L. B. McBrayer.....	L. B. McBrayer.....	1,663	10	107
74 1927	Durham.....	653	Wm. deB. MacNider.....	J. P. Matheson, W. W. Dawson, H. H. Bass.....	L. B. McBrayer.....	L. B. McBrayer.....	1,691	10	121
75 1928	Pinehurst.....	611	John Q. Myers.....	J. W. Carroll, A. Y. Linville, C. H. Cocke.....	L. B. McBrayer.....	L. B. McBrayer.....	1,738	11	143
76 1929	Greensboro.....	671	John T. Burrus.....	G. H. Macon, R. F. Leinbach, W. R. Griffin.....	L. B. McBrayer.....	L. B. McBrayer.....	1,666	11	146
77 1930	Pinehurst.....	701	Thurman D. Kitchin.....	W. L. Dunn, Asheville, D. T. Tayloe, Jr., Washington, W. D. James, Hamlet.....	L. B. McBrayer.....	L. B. McBrayer.....	1,711	11	155
			L. A. Crowell.....	W. B. Murphy, Wm. E. Warren, N. B. Adams.....	L. B. McBrayer.....	L. B. McBrayer.....			

HISTORY OF THE MEDICAL SOCIETY OF THE STATE OF NORTH CAROLINA FROM 1849 TO 1966—Continued

Date	Place of Meeting	Number in Attendance	President	President-Elect	Vice Presidents	Sec.-Treas.	Members on Roll July 15	Honorary Members	Life Members
78 1931	Durham	714	J. G. Murphy	M. L. Stevens	C. A. Julian J. W. Davis	L. B. McBrayer	1,600	10	164
79 1932	Winston-Salem	740	M. L. Stevens	Jno. B. Wright	C. W. Banner W. W. Sawyer	L. B. McBrayer L. B. McBrayer	1,559 1,363	10 10	166 181
80 1933	Raleigh	714	Jno. B. Wright	I. H. Mannings	J. R. McCracken				
81 1934	Pinehurst	728	I. H. Manning	P. P. McCain	W. G. Suiter R. L. Felts	L. B. McBrayer	1,563	10	210
82 1935	Pinehurst	706	P. P. McCain	Paul H. Ringer	H. D. Walker J. F. McKay William Allan	L. B. McBrayer	1,619	10	215
83 1936	Asheville	583	Paul H. Ringer	C. F. Strosnider	J. K. Pepper E. S. Bullock	L. B. McBrayer	1,462	10	235
84 1937	Winston-Salem	767	C. F. Strosnider	Wingate M. Johnson	C. A. Woodard Jno. F. Brownsberger	L. B. McBrayer	1,503	7	263
85 1938	Pinehurst	802	Wingate M. Johnson	J. Buren Sidbury	R. B. McKnight J. F. Abel	T. W. M. Long	1,715	7	284
86 1939	Cruise to Bermuda	319	J. Buren Sidbury	William Allan	C. B. Williams M. D. Hill	T. W. M. Long	1,605	8	313
87 1940	Pinehurst	835	William Allan	Hubert B. Haywood	F. Webb Griffith Frank C. Smith	T. W. M. Long	1,661	7	311
88 1941	Pinehurst	755	Hubert B. Haywood	F. Webb Griffith	D. W. Holt T. C. Kerns	T. W. M. Long(1) I. H. Manning	1,700	7	309
89 1942	Charlotte	710	F. Webb Griffith	Donnel B. Cobb	Thos. DeL. Sparrow T. L. Carter	Roscoe D. McMillan	1,837	8	360
90 1943	Raleigh	736	Donnell B. Cobb	James W. Vernon	George S. Coleman Julian Moore	Roscoe D. McMillan	1,919	8	361
91 1944	Pinehurst	760	James W. Vernon	Paul F. Whitaker	Fred C. Hubbard George L. Carrington	Roscoe D. McMillan	1,982	8	363
1945	No meeting because of O.D.T. restrictions		Paul F. Whitaker	Oren Moore	Wm. H. Smith Zack D. Owens	Roscoe D. McMillan	1,811	7	383
92 1946	Pinehurst	889	Oren Moore		Wm. H. Smith Zack D. Owens	Roscoe D. McMillan	1,939	6	397
93 1947	Virginia Beach, Va.	444	Wm M. Coppridge	Frank A. Sharpe	G. E. Bell J. B. Bullitt	Roscoe D. McMillan	2,191	7	404
94 1948	Pinehurst	920	Frank A. Sharpe(2)	James F. Robertson	V. K. Hart J. G. Raby	Roscoe D. McMillan	2,298	8	407
95 1949	Pinehurst	998	James F. Robertson	G. Westbrook Murphy	Joseph J. Combs Joseph A. Elliott	Roscoe D. McMillan	2,318	5	405
96 1950	Pinehurst	947	G. Westbrook Murphy	Roscoe D. McMillan	Ben F. Royal Joseph A. Elliott	Millard D. Hill	2,283	5	455
97 1951	Pinehurst	938	Roscoe D. McMillan	Frederic C. Hubbard	Joseph A. Elliot Henderson Irwin	Millard D. Hill	2,341	5	469
98 1952	Pinehurst	969	Frederic C. Hubbard	J. Street Brewer	Forest M. Houser Arthur Daughtridge	Millard D. Hill	2,326	5	476
99 1953	Pinehurst	1016	J. Street Brewer	Joseph A. Elliott	George W. Paschal John R. Bender	Millard D. Hill	2,673	5	486
100 1954	Pinehurst	1077	Joseph A. Elliott	Zack D. Owens	John F. Foster Julian A. Moore	Millard D. Hill	2,801	6	486
101 1955	Pinehurst	991	Zack D. Owens	J. P. Rousseau	George W. Paschal, Jr. Elias S. Faison	Millard D. Hill	2,896	6	507
102 1956	Pinehurst	1022	James P. Rousseau	Donald B. Koonce	E. W. Schoenheit Milton S. Clark	Millard D. Hill	3,058	7	561
103 1957	Asheville	867	Donald B. Koonce	Edward W. Schoenheit	John S. Rhodes O. Norris Smith	Millard D. Hill	3,127	8	522
104 1958	Asheville	781	Edw. W. Schoenheit	Lenox D. Baker	George W. Holmes Amos N. Johnson	Millard D. Hill	3,171	9	642
105 1959	Asheville	651	Lenox D. Baker	John C. Reece	Amos N. Johnson Kenneth B. Geddies	John S. Rhodes	3,211	10	251
106 1960	Raleigh	848	John C. Reece	Amos N. Johnson	Charles M. Norfleet, Jr. W. Walton Kitchin	John S. Rhodes	3,247	12	472
107 1961	Asheville	636	Amos N. Johnson	Claude B. Squires	Theodore S. Raiford Charles T. Wilkinson	John S. Rhodes	3,248	12	438
108 1962	Raleigh	745	Claude B. Squires	John R. Kernodle	John A. Payne, III J. Sam Holbrook	John S. Rhodes	3,339	9	425
109 1963	Asheville	714	John R. Kernodle	John S. Rhodes	H. Fleming Fuller Jacob H. Shuford	Charles W. Styron	3,491	9	431
110 1964	Greensboro	677	John S. Rhodes	T. S. Raiford	Wm. F. Hollister F. G. Patterson	Charles W. Styron	3,473	8	398
111 1965	Charlotte	738	T. S. Raiford	George W. Paschal, Jr.	Hubert McN. Poteat Wayne J. Benton	Charles W. Styron	3,516	8	390
112 1966	Asheville	545	George W. Paschal, Jr.	Frank W. Jones	W. Otis Duck John L. McCain	Charles W. Styron	3,597	12	339

†Died during his term of office; succeeded by E. J. Wood, first vice president

‡Died during term of office

(2) Died during term of office; succeeded by I. H. Manning. (2) Died during term of office; succeeded by James F. Robertson, president-elect.

STATUS OF SOCIETY MEMBERSHIP BY COUNTIES FOR YEARS 1932-1966

COUNTY	1952	1953	1954	1955	1956	1957	1958	1959	1960	1961	1962	1963	1964	1965	1966
Alamance-Caswell	54	58	62	62	62	63	65	66	66	67	70	70	72	71	76
Alexander 1	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	7	6	5	----
Alleghany 2	-----	-----	-----	-----	-----	-----	-----	-----	-----	4	11	4	4	6	6
Anson	11	11	10	11	10	10	8	8	10	-----	8	8	9	6	7
Ashe 3	-----	-----	-----	-----	11	8	8	9	13	8	-----	8	8	8	6
Ashe-Watauga	15	16	18	22	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----
Avery 4	7	10	10	9	8	9	9	9	11	10	10	13	11	11	12
Beaufort	15	19	16	15	16	17	20	19	18	19	37	20	22	21	21
Bertie	7	7	10	10	10	10	10	10	10	10	8	8	9	8	8
Bladen	8	10	10	11	11	11	12	11	12	10	10	10	10	10	9
Brunswick	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	5	5	5
Buncombe	132	154	162	159	174	175	175	170	170	172	175	174	179	189	183
Burke	32	34	38	35	38	35	36	34	34	35	36	36	40	43	43
Cabarrus	44	42	51	47	52	59	59	58	62	60	61	58	59	57	63
Caldwell	25	25	25	23	26	28	27	26	27	29	31	32	34	34	31
Camden 5	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	1	1	----
Carteret	14	15	16	16	16	17	18	19	20	20	20	20	19	21	21
Caswell 6	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	1	1	----
Catawba	27	37	38	42	46	47	49	51	52	53	58	61	64	65	65
Chatham	4	10	10	10	11	11	12	13	13	15	13	14	12	9	10
Cherokee	9	8	8	9	10	11	11	10	10	11	10	11	11	10	11
Chowan-Perquimans	7	8	10	11	12	12	10	11	10	9	11	11	10	10	----
Clay 7	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----
Cleveland	36	36	37	42	44	47	45	45	46	43	44	49	48	49	49
Columbus	16	19	19	20	19	23	22	24	23	21	20	22	22	21	20
Craven	13	20	23	26	25	24	27	27	26	28	28	31	31	31	35
Cumberland	42	41	41	46	51	50	56	58	58	59	59	60	58	60	64
Currituck 8	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	2	2	----
Dare 5	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	2	2	----
Davidson	33	36	36	37	35	35	40	43	41	40	38	38	38	38	36
Davie 9	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	6	7	----
Duplin	9	10	13	13	16	18	15	15	15	13	13	14	13	16	17
Durham-Orange	152	217	251	261	285	300	313	314	325	344	355	360	378	478	400
Edgecombe-Nash	53	55	64	58	62	67	66	65	61	65	69	66	68	70	70
Forsyth	151	173	176	186	203	213	221	221	220	22	221	234	236	247	240
Franklin	10	10	8	10	10	10	10	12	10	10	13	11	12	10	11
Gaston	55	59	60	63	70	69	70	70	72	73	73	74	77	80	78
Gates	3	3	3	3	3	3	3	3	3	2	2	2	1	1	1
Graham	-----	2	2	2	-----	-----	-----	-----	-----	-----	-----	-----	-----	1	1
Granville	14	13	17	16	19	21	25	26	27	29	28	25	28	29	32
Greene	3	3	3	3	3	3	3	-----	-----	2	-----	2	2	2	2
Guilford	160	196	198	199	215	214	214	220	221	232	240	242	253	258	263
Halifax	23	25	29	32	31	32	32	33	32	29	28	28	25	27	27
Harnett	17	19	13	20	19	19	19	19	21	22	23	24	25	23	23
Haywood	20	21	25	22	26	26	31	33	35	34	33	31	32	32	29
Henderson	19	22	30	31	32	34	34	36	34	34	31	32	32	31	30
Hertford	13	14	14	16	17	14	15	16	16	17	16	16	16	15	15
Hoke	11	12	15	13	12	14	12	12	12	13	14	13	14	13	12
Hyde	-----	-----	-----	-----	-----	-----	-----	-----	-----	1	-----	1	1	1	1
Iredell-Alexander	36	42	50	49	47	48	48	47	47	47	52	47	49	56	55
Jackson 10	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	11	13	13	13
Jackson-Swain	15	15	14	14	15	16	16	15	16	15	12	-----	-----	-----	-----
Johnston	33	35	35	37	39	36	35	36	32	30	32	33	31	35	34
Jones	1	1	1	1	1	2	1	-----	-----	1	1	2	2	2	2
Lee	15	16	18	17	16	16	16	17	16	17	19	20	20	21	22
Lenoir	35	37	37	36	41	40	42	47	49	50	49	50	51	50	48
Lincoln	13	14	12	12	10	13	12	12	13	12	12	13	14	14	14
Macon-Clay	7	10	9	9	9	12	11	10	11	11	9	9	10	10	8
Madison	6	7	7	10	6	7	7	7	10	8	6	6	6	6	6
Martin 11	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----
Martin-Washington-Tyrrell	21	18	16	15	16	16	17	17	16	15	-----	16	8	16	16
McDowell	10	11	13	11	12	12	12	11	11	11	11	11	11	10	11
Mecklenburg	188	229	231	252	270	271	284	289	290	310	314	320	333	348	345
Mitchell 12	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----

STATUS OF MEMBERSHIP BY COUNTIES—Continued

	1952	1953	1954	1955	1956	1957	1958	1959	1960	1961	1962	1963	1964	1965	1966
Mitchell-Avery 13															
Mitchell-Watauga 14															
Mitchell-Yancey	10	10	10	9	9	9	9	10	13	11	12	10	11	11	11
Montgomery 15	11	10	11	11	10	11	8	7	7	8	8	7	7	7	7
Moore	26	29	33	35	34	32	31	32	32	31	32	37	35	36	37
Nash 16															
New Hanover	63	65	68	69	73	76	77	76	80	80	79	81	74	73	75
Northampton	3	5	4	3	3	4	4	4	4	3	3	3	3	4	4
Onslow	1	10	10	10	12	13	12	12	14	15	18	16	13	15	13
Orange 17															
Pamlico	4	4	5	5	5	4	4	4	4	3	3	1	2	1	1
Pasquotank-Camden-															
Currituck-Dare	26	27	25	27	28	29	28	26	26	28	28	27	22	27	26
Pasquotank-Camden-Dare 8															
Pender													4	4	4
Perquimans 18															
Person	9	9	9	9	10	10	10	10	11	12	12	11	11	11	10
Pitt	2	34	40	43	46	44	41	43	41	42	44	43	46	46	48
Polk	5	6	6	8	10	11	10	11	11	12	13	13	16	15	17
Randolph	21	26	24	28	28	28	26	28	27	28	31	29	31	31	31
Richmond	18	22	23	21	20	19	20	22	22	25	23	22	21	22	22
Robeson	42	42	44	48	45	43	46	49	48	49	47	50	50	50	50
Rockingham	30	30	32	37	36	37	34	35	39	40	39	40	39	38	38
Rowan-Davie	42	45	48	58	63	60	62	63	63	63	67	53	60	63	62
Rutherford	25	25	24	25	26	27	25	27	25	25	24	25	25	26	25
Sampson	18	17	19	19	20	19	19	17	17	17	19	19	19	19	18
Scotland	14	14	14	14	14	13	13	16	14	17	19	17	17	18	19
Stanly 15	24	25	26	29	29	29	27	27	28	27	27	25	27	25	21
Stanly-Montgomery															
Stokes												3	5	5	5
Surry 19															
Surry-Yadkin	23	28	28	28	30	35	38	38	37	39	30	42	38	39	39
Swain 10											4	5	5	5	4
Transylvania	7	10	10	11	9	11	11	12	13	12	13	14	13	15	14
Tyrrell 20															
Union	16	17	15	15	16	17	16	15	15	16	19	19	19	17	19
Vance	12	13	14	15	17	16	14	16	15	15	15	17	15	15	14
Wake	114	146	152	147	155	156	158	159	165	172	182	188	189	192	200
Warren	5	7	8	9	9	8	8	7	8	8	7	6	6	4	5
Washington-Tyrrell 11															
Watauga					11	10	10	9	9	10	11	11	12	12	10
Watauga-Ashe 22															
Wayne	38	41	37	39	42	43	44	47	50	52	50	55	56	56	56
Wilkes 2												18	19	19	19
Wilkes-Alleghany	17	17	18	21	20	21	22	23	17	18	18				
Wilson	30	34	34	37	36	38	39	38	40	42	43	44	46	49	52
Yadkin 19															
Yancey															

Totals 2,326 2,673 2,801 2,896 3,058 3,127 3,171 3,211 3,247 3,322 3,351 3,429 3,515 3,566 3,597

(1) See Iredell - Alexander. (2) See Wilkes-Alleghany. (3) See Watauga-Ashe and Ashe-Watauga. (4) See Mitchell-Avery. (5) See Pasquotank-Camden-Dare and Pasquotank-Camden-Currituck-Dare. (6) See Alamance-Caswell. (7) See Macon-Clay. (8) See Pasquotank-Camden-Currituck-Dare. (9) See Rowan-Davie. (10) See Jackson-Swain. (11) See Martin-Washington-Tyrrell. (12) See Mitchell-Avery, Mitchell-Watauga, and Mitchell-Yancey. (13) See Avery and Mitchell. (14) See Mitchell, Watauga-Ashe, and Ashe-Watauga. (15) See Stanly-Montgomery, Montgomery, and Stanly. (16) See Edgecombe-Nash. (17) See Durham-Orange. (18) See Chowan-Perquimans. (19) See Surry-Yadkin. (20) See Washington-Tyrrell and Martin-Washington-Tyrrell. (21) See Mitchell-Watauga, Watauga-Ashe, and Ashe-Watauga. (22) See Ashe-Watauga.

ROSTER OF MEMBERS OF NORTH CAROLINA STATE BOARD OF HEALTH FROM ORGANIZATION IN 1877 TO 1966

<i>Name</i>	<i>Address</i>	<i>Appointed by</i>	<i>Term</i>
S. S. Satchwell, M.D., President	Rocky Point	State Society	1877 to 1878
Thomas F. Wood, M.D., Secretary	Wilmington	State Society	1877 to 1878
Joseph Graham, M.D.	Charlotte	State Society	1877 to 1878
Charles Duffy, Jr., M.D.	New Bern	State Society	1877 to 1878
Peter E. Hines, M.D.	Raleigh	State Society	1877 to 1878
George A. Foote, M.D.	Warrenton	State Society	1877 to 1878
S. S. Satchwell, M.D., President	Rocky Point	State Society	1878 to 1884
Thomas F. Wood, M.D., Secretary	Wilmington	State Society	1878 to 1884
Charles J. O'Hagan, M.D., President	Greenville	State Society	1878 to 1882
George A. Foote, M.D.	Warrenton	State Society	1878 to 1882
Marcellus Whitehead, M.D.	Salisbury	State Society	1878 to 1880
R. L. Payne, M.D.	Lexington	State Society	1878 to 1880
H. G. Woodfin, M.D.	Franklin	Gov. Z. B. Vance	1878 to 1880
A. R. Ledoux, Chemist	Chapel Hill	Gov. Z. B. Vance	1878 to 1880
William Cain, Civil Engineer	Charlotte	Gov. Z. B. Vance	1878 to 1880
R. L. Payne, M.D.	Lexington	State Society	1881 to 1887
M. Whitehead, M.D., President	Salisbury	State Society	1881 to 1884
S. H. Lyle, M.D.	Franklin	Gov. T. J. Jarvis	1881 to 1883
William Cain, Civil Engineer	Charlotte	Gov. T. J. Jarvis	1881 to 1883
W. G. Simmons, Chemist	Wake Forest	Gov. T. J. Jarvis	1881 to 1883
J. W. Jones, M.D., President	Wake Forest	State Society	1883 to 1889
John McDonald, M.D.	Washington	State Society	1883 to 1889
S. H. Lyle, M.D.	Franklin	Gov. T. J. Jarvis	1883 to 1885
W. G. Simmons, Chemist	Wake Forest	Gov. T. J. Jarvis	1883 to 1885
Arthur Winslow, Civil Engineer	Raleigh	Gov. T. J. Jarvis	1884 to 1886
R. H. Lewis, M.D.	Raleigh	State Board of Health	1884 to 1886
Thomas F. Wood, M.D., Secretary	Wilmington	State Society	1885 to 1887
William D. Hilliard, M.D.	Asheville	State Society	1885 to 1891
Arthur Winslow, Civil Engineer	Raleigh	Gov. A. M. Scales	1885 to 1891
W. G. Simmons, Chemist	Wake Forest	Gov. A. M. Scales	1885 to 1887
J. H. Tucker, M.D.	Henderson	Gov. A. M. Scales	1885 to 1887
R. H. Lewis, M.D., Secretary	Raleigh	State Society	1887 to 1888
H. T. Bahnson, M.D., President	Winston	State Society	1887 to 1888
Arthur Winslow, Civil Engineer	Raleigh	Gov. A. M. Scales	1887 to 1889
W. G. Simmons, Chemist	Wake Forest	Gov. A. M. Scales	1887 to 1889
J. H. Tucker, M.D.	Henderson	Gov. A. M. Scales	1888 to 1891
J. L. Ludlow, Civil Engineer	Winston	Gov. A. M. Scales	1888 to 1891
J. H. Tucker, M.D.	Henderson	Gov. D. G. Fowle	1888 to 1891
F. P. Venable, Ph.D. Chemist	Chapel Hill	Gov. D. G. Fowle	1889 to 1893
J. L. Ludlow, Civil Engineer	Winston	Gov. D. G. Fowle	1889 to 1892
J. A. Hodges, M.D.	Fayetteville	State Society	1889 to 1893
J. M. Baker, M.D.	Tarboro	State Society	1891 to 1893
J. H. Tucker, M.D.	Henderson	Gov. T. M. Holt	1891 to 1893
F. P. Venable, Ph.D., Chemist	Chapel Hill	Gov. T. M. Holt	1891 to 1892
J. L. Ludlow, Civil Engineer	Winston	Gov. T. M. Holt	1892 to 1897
Thomas F. Wood, M.D., Secretary†	Wilmington	State Society	1891 to 1895
George G. Thomas, M.D., President	Wilmington	State Board of Health	1892 to 1895
S. Westray Battle, M.D.	Asheville	State Society	1893 to 1895
W. H. Harrell, M.D.	Williamston	State Society	1893 to 1895
John Whitehead, M.D.	Salisbury	State Board of Health	1893 to 1895
W. H. G. Lucas	White Hall	Gov. Elias Carr	1893 to 1895
F. P. Venable, Ph.D., Chemist	Chapel Hill	Gov. Elias Carr	1893 to 1895
John C. Chase, Civil Engineer	Wilmington	Gov. Elias Carr	1894 to 1897
R. H. Lewis, M.D., Secretary	Raleigh	Gov. Elias Carr	1895 to 1897
W. P. Beall, M.D.	Greensboro	Gov. Elias Carr	1895 to 1897
W. J. Lumsden, M.D.	Elizabeth City	Gov. Elias Carr	1895 to 1897
John Whitehead, M.D.	Salisbury	State Society	1895 to 1897
W. H. Harrell, M.D.	Williamston	State Society	1895 to 1897
W. P. Beall, M.D.	Greensboro	Gov. Elias Carr	1895 to 1897
R. H. Lewis, M.D., Secretary	Raleigh	Gov. Elias Carr	1897 to 1899
F. P. Venable, Ph.D., Chemist	Chapel Hill	Gov. Elias Carr	1897 to 1899
John C. Chase, Civil Engineer	Wilmington	Gov. Elias Carr	1897 to 1899
Charles J. O'Hagan, M.D.	Greenville	Gov. D. L. Russell	1897 to 1899
John D. Spicer, M.D.	Goldsboro	Gov. D. L. Russell	1897 to 1899
J. L. Nicholson, M.D.	Richlands	Gov. D. L. Russell	1899 to 1901
R. H. Lewis, M.D., Secretary	Raleigh	Gov. D. L. Russell	1899 to 1901
A. W. Shaffer, Civil Engineer	Raleigh	Gov. D. L. Russell	1899 to 1901
Charles J. O'Hagan, M.D.	Greenville	Gov. D. L. Russell	1899 to 1901
J. L. Nicholson, M.D.	Richlands	Gov. D. L. Russell	1899 to 1901
Albert Anderson, M.D.	Wilson	Gov. D. L. Russell	1899 to 1901
George G. Thomas, M.D., President	Wilmington	State Society	1899 to 1901

† Died in 1892, leaving a five-year unexpired term, which was filled by the Board

Name	Address	Appointed by	Term
S. Westray Battle, M.D.	Asheville	State Society	1899 to 1901
H. W. Lewis, M.D.	Jackson	State Society	1899 to 1901
H. H. Dodson, M.D.	Milton	State Society	1901 to 1907
R. H. Lewis, M.D., Secretary	Raleigh	Gov. C. B. Aycock	1901 to 1907
W. P. Ivey, M.D.	Lenoir	Gov. C. B. Aycock	1901 to 1907
George G. Thomas, M.D., President	Wilmington	Gov. C. B. Aycock	1901 to 1905
Francis Duffy, M.D.	New Bern	Gov. C. B. Aycock	1901 to 1905
J. L. Ludlow, Civil Engineer	Winston	Gov. C. B. Aycock	1901 to 1905
S. Westray Battle, M.D.	Asheville	State Society	1901 to 1907
H. W. Lewis, M.D.	Jackson	State Society	1901 to 1907
W. H. Whitehead, M.D.	Rocky Mount	State Society	1901 to 1905
J. L. Nicholson, M.D.	Richlands	State Society	1901 to 1905
J. L. Ludlow, Civil Engineer	Winston	Gov. C. B. Aycock	1903 to 1909
J. Howell Way, M.D.	Waynesville	Gov. R. B. Glenn	1905 to 1911
W. O. Spencer, M.D.	Winston	Gov. R. B. Glenn	1905 to 1911
George G. Thomas, M.D., President	Wilmington	State Society	1905 to 1911
Thomas E. Anderson, M.D.	Statesville	State Society	1907 to 1913
R. H. Lewis, M.D.	Raleigh	Gov. R. B. Glenn	1907 to 1913
E. C. Register, M.D.	Charlotte	Gov. R. B. Glenn	1907 to 1909
David T. Tayloe, M.D.	Washington	State Society	1907 to 1913
James A. Burroughs, M.D. ¹	Asheville	State Society	1909 to 1913
J. E. Ashcraft, M.D.	Monroe	State Board of Health	1909 to 1913
J. L. Ludlow, Civil Engineer	Winston-Salem	Gov. W. W. Kitchin	1911 to 1917
J. Howell Way, M.D., President	Waynesville	Gov. W. W. Kitchin	1911 to 1917
W. O. Spencer, M.D.	Winston-Salem	Gov. W. W. Kitchin	1911 to 1917
Thomas E. Anderson, M.D.	Statesville	State Society	1911 to 1917
Charles O'H. Laughinghouse, M.D.	Greenville	State Society	1913 to 1919
R. H. Lewis, M.D.	Raleigh	Gov. Locke Craig	1913 to 1919
Edw. J. Wood, M.D.	Wilmington	Gov. Locke Craig	1913 to 1915
A. A. Kent, M.D. ²	Lenoir	State Society	1913 to 1919
Cyrus Thompson, M.D.	Jacksonville	State Society	1913 to 1919
Fletcher R. Harris, M.D.	Henderson	State Board of Health	1915 to 1921
J. L. Ludlow, Civil Engineer	Winston-Salem	Gov. Locke Craig	1917 to 1923
J. Howell Way, M.D., President	Waynesville	Gov. T. W. Bickett	1917 to 1923
E. C. Register, M.D. ¹	Charlotte	Gov. T. W. Bickett	1917 to 1923
Thomas E. Anderson, M.D.	Statesville	State Society	1917 to 1923
Charles O'H. Laughinghouse, M.D.	Greenville	State Society	1919 to 1923
Fletcher R. Harris, M.D. ³	Henderson	State Society	1919 to 1923
A. J. Crowell, M.D.	Charlotte	Gov. T. W. Bickett	1921 to 1923
Chas. E. Waddell, C. E. ⁴	Asheville	Gov. C. Morrison	1919 to 1925
Cyrus Thompson, M.D.	Jacksonville	State Society	1919 to 1925
R. H. Lewis, M.D.	Raleigh	Gov. T. W. Bickett	1923 to 1925
E. J. Tucker, D.D.S.	Roxboro	Gov. T. W. Bickett	1923 to 1929
J. Howell Way, M.D., President	Waynesville	Gov. C. Morrison	1923 to 1929
A. J. Crowell, M.D.	Charlotte	Gov. C. Morrison	1923 to 1927
James P. Stowe, Ph.G.	Charlotte	Gov. C. Morrison	1923 to 1925
D. A. Stanton, M.D.	High Point	State Board of Health	1923 to 1929
Thomas E. Anderson, M.D.	Statesville	State Society	1923 to 1926
Charles O'H. Laughinghouse, M.D. ⁵	Greenville	State Society	1925 to 1931
Cyrus Thompson, M.D. ¹	Jacksonville	State Society	1925 to 1931
D. A. Stanton, M.D.	High Point	State Society	1925 to 1931
R. H. Lewis, M.D. ¹	Raleigh	Gov. A. W. McLean	1926 to 1931
Jno. B. Wright, M.D. ⁶	Raleigh	Gov. A. W. McLean	1925 to 1931
E. J. Tucker, D.D.S. ⁶	Roxboro	Gov. A. W. McLean	1926 to 1927
W. S. Rankin, M.D. ⁴	Charlotte	State Board of Health	1927 to 1929
L. E. McDaniel, M.D.	Jackson	State Board of Health	1927 to 1929
Chas. C. Orr, M.D.	Asheville	Gov. A. W. McLean	1929 to 1935
Thomas E. Anderson, M.D. ⁶	Statesville	State Society	1929 to 1935
L. E. McDaniel, M.D. ⁶	Jackson	State Society	1927 to 1933
James P. Stowe, Ph.G. ⁶	Charlotte	Gov. A. W. McLean	1929 to 1935
A. J. Crowell, M.D. ⁶	Charlotte	Gov. O. Max Gardner	1930 to 1931
J. M. Parrott, M.D. ⁶	Kinston	State Board of Health	1929 to 1935
Chas. C. Orr, M.D. ⁶	Asheville	Gov. O. Max Gardner	1931 to 1935
J. M. Parrott, M.D. ⁵	Kinston	State Society	1931 to 1935
C. V. Reynolds, M.D.	Asheville	State Society	1931 to 1933
L. B. Evans, M.D.	Windsor	State Society	1931 to 1933
S. D. Craig, M.D.	Winston-Salem	State Society	1931 to 1933
John T. Burrus, M.D.	High Point	Gov. O. Max Gardner	1931 to 1933
J. N. Johnson, D.D.S.	Goldsboro	Gov. O. Max Gardner	1931 to 1933
J. A. Goode, Ph.G.	Asheville	Gov. O. Max Gardner	1931 to 1933
H. L. Large, M.D.	Rocky Mount	Gov. O. Max Gardner	1931 to 1935
H. G. Baity, C.E.	Chapel Hill	Gov. O. Max Gardner	1931 to 1935

¹ Died leaving unexpired term.² Resigned to become member of General Assembly.³ Resigned to become Health Officer Vance County.⁴ Resigned.⁵ Resigned to become Secretary of State Board of Health⁶ Term terminated on account of the reorganization of the State Board of Health by General Assembly.

<i>Name</i>	<i>Address</i>	<i>Appointed by</i>	<i>Term</i>
Grady G. Dixon, M.D. ⁷	Ayden	Ex. Com. State Society	1931 to 1932
Grady G. Dixon, M.D. ⁷	Ayden	State Society	1932 to 1935
S. D. Craig, M.D.	Winston-Salem	State Society	1933 to 1937
W. T. Rainey, M.D.	Fayetteville	State Society	1933 to 1937
J. N. Johnson, D.D.S.	Goldsboro	Gov. J. C. B. Ehringhaus	1933 to 1937
Hubert B. Haywood, M.D.	Raleigh	Gov. J. C. B. Ehringhaus	1933 to 1937
James P. Stowe, Ph.G.	Charlotte	Gov. J. C. B. Ehringhaus	1933 to 1937
Grady G. Dixon, M.D.	Ayden	State Society	1935 to 1939
J. LaBruce Ward, M.D.	Asheville	State Society	1935 to 1939
H. Lee Large, M.D.	Rocky Mount	Gov. J. C. B. Ehringhaus	1935 to 1939
H. G. Baity, C.E.	Chapel Hill	Gov. J. C. B. Ehringhaus	1935 to 1939
J. N. Johnson, D.D.S.	Goldsboro	Gov. Clyde R. Hoey	1937 to 1941
Hubert B. Haywood, M.D.	Raleigh	Gov. Clyde R. Hoey	1937 to 1941
James P. Stowe, Ph.G.	Charlotte	Gov. Clyde R. Hoey	1937 to 1941
S. D. Craig, M.D.	Winston-Salem	State Society	1937 to 1941
W. T. Rainey, M.D.	Fayetteville	State Society	1937 to 1941
Grady G. Dixon, M.D.	Ayden	State Society	1939 to 1943
J. LaBruce Ward, M.D.	Asheville	State Society	1939 to 1943
H. Lee Large, M.D.	Rocky Mount	Gov. Clyde R. Hoey	1939 to 1943
H. G. Baity, Sc.D.	Chapel Hill	Gov. Clyde R. Hoey	1939 to 1943
C. C. Fordham, Jr., Ph.G. ⁸	Greensboro	Gov. Clyde R. Hoey	1940 to 1943
S. D. Craig, M.D.	Winston-Salem	State Society	1941 to 1945
W. T. Rainey, M.D.	Fayetteville	State Society	1941 to 1945
Hubert B. Haywood, M.D.	Raleigh	Gov. J. Melville Broughton	1941 to 1945
J. N. Johnson, D.D.S.	Goldsboro	Gov. J. Melville Broughton	1941 to 1945
James O. Nolan, M.D.	Kannapolis	Gov. J. Melville Broughton	1941 to 1945
Grady G. Dixon, M.D.	Ayden	State Society	1943 to 1947
J. LaBruce Ward, M.D.	Asheville	State Society	1943 to 1947
H. Lee Large, M.D.	Rocky Mount	Gov. J. Melville Broughton	1943 to 1947
Larry I. Moore, Jr.	Wilson	Gov. J. Melville Broughton	1943 to 1947
S. D. Craig, M.D., Pres.	Winston-Salem	State Society	1945 to 1949
W. T. Rainey, M.D.	Fayetteville	State Society	1945 to 1949
Hubert B. Haywood, M.D.	Raleigh	Gov. R. Gregg Cherry	1945 to 1949
James O. Nolan, M.D.	Kannapolis	Gov. R. Gregg Cherry	1945 to 1949
Paul Jones, D.D.S. ⁹	Farmville	Gov. R. Gregg Cherry	1946 to 1949
Jasper C. Jackson, Ph.G. ¹⁰	Lumberton	Gov. R. Gregg Cherry	1945 to 1947
Grady G. Dixon, M.D., Pres.	Ayden	State Society	1947 to 1951
H. Lee Large, M.D.	Rocky Mount	Gov. R. Gregg Cherry	1947 to 1951
J. LaBruce Ward, M.D.	Asheville	State Society	1947 to 1951
Hubert B. Haywood, M.D.	Raleigh	Gov. W. Kerr Scott	1949 to 1953
Mrs. James B. Hunt	Lucama	Gov. W. Kerr Scott	1949 to 1953
A. C. Current, D.D.S.	Gastonia	Gov. W. Kerr Scott	1949 to 1953
John R. Bender, M.D.	Winston-Salem	State Society	1949 to 1953
Benjamin J. Lawrence, M.D.	Raleigh	State Society	1949 to 1953
G. Grady Dixon, M.D.	Ayden	Medical Society	1951 to 1955
George Curtis Crump, M.D.	Asheville	Medical Society	1951 to 1955
John P. Henderson, Jr., M.D. ¹¹	Sneads Ferry	Gov. Wm. B. Umstead	1954 to 1955
H. C. Lutz, Phg.	Hickory	Gov. W. Kerr Scott	1951 to 1955
Hubert B. Haywood, M.D. ¹²	Raleigh	Gov. Wm. Umstead	1953 to 1957
Mrs. J. E. Latta	Hillsboro	Gov. Wm. Umstead	1953 to 1957
A. C. Current, D.D.S.	Gastonia	Gov. Wm. Umstead	1953 to 1957
John R. Bender, M.D.	Winston-Salem	Medical Society	1953 to 1957
Benjamin J. Lawrence, M.D.	Raleigh	Medical Society	1953 to 1957
G. Grady Dixon, M.D. ¹⁵	Ayden	Medical Society	1955 to 1959
George Curtis Crump, M.D. ¹²	Asheville	Medical Society	1955 to 1959
Roger W. Morrison, M.D. ¹⁴	Asheville	Medical Society	1957 to 1957
John P. Henderson, Jr., M.D.	Sneads Ferry	Gov. Luther H. Hodges	1955 to 1959
H. C. Lutz, Phg.	Hickory	Gov. Luther H. Hodges	1955 to 1959
Lenox D. Baker, M.D. ¹³	Durham	Gov. Luther H. Hodges	1956 to 1957
Earl W. Brain, M.D. ¹⁶	Raleigh	Medical Society	1958 to 1959
Mrs. J. E. Latta	Hillsboro	Gov. Luther H. Hodges	1957 to 1961
Roger W. Morrison, M.D.	Asheville	Medical Society	1957 to 1959
John R. Bender, M. D.	Winston-Salem	Medical Society	1957 to 1961
Z. L. Edwards, D.D.S.	Washington	Gov. Luther H. Hodges	1957 to 1961
Chas. R. Bugg, M.D., Pres. ¹⁷	Raleigh	Medical Society	1957 to 1961
Lenox D. Baker, M.D.	Durham	Gov. Luther H. Hodges	1957 to 1961

7 To fill vacancy caused by resignation of Dr. J. M. Parrott.

8 To fill vacancy caused by the death of James P. Stowe, Ph.G.

9 To fill vacancy caused by resignation of J. N. Johnson, D.D.S.

10 To fill vacancy caused by resignation of Larry I. Moore, Jr.

11 To fill vacancy caused by the death of Dr. H. Lee Large.

12 Resigned

13 To fill vacancy caused by resignation of Dr. Hubert B. Haywood.

14 To fill vacancy caused by resignation of Dr. George Curtis Crump

15 Died leaving unexpired term.

16 To fill vacancy caused by the death of Dr. G. Grady Dixon.

17 Died leaving unexpired term.

ROSTER OF MEMBERS OF THE VARIOUS BOARDS OF MEDICAL EXAMINERS
OF THE STATE OF NORTH CAROLINA

Name	Address	Appointed by	Term
Ben W. Dawsey, D.V.M.	Gastonia	Gov. Luther H. Hodges	1959 to 1963
Rogert W. Morrison, M.D.	Asheville	Medical Society	1959 to 1963
Jasper C. Jackson, Phg.	Lumberton	Gov. Luther H. Hodges	1959 to 1963
Oscar S. Goodwin, M.D.	Apex	Medical Society	1959 to 1963
*Chas. R. Bugg, M.D., Pres.	Raleigh	Medical Society	1961 to 1965
Lenox D. Baker, M.D.	Durham	Gov. Terry Sanford	1961 to 1965
D. T. Redfern	Wadesboro	Gov. Terry Sanford	1961 to 1965
Glenn L. Hooper, D.D.S.	Dunn	Gov. Terry Sanford	1961 to 1965
John R. Bender, M.D.	Winston-Salem	Medical Society	1961 to 1965
John S. Rhodes, M.D. ¹⁸	Raleigh	Medical Society	1961 to 1965
S. G. Koonce	Chadbourn	Gov. Terry Sanford	1963 to 1967
James S. Raper, M.D.	Asheville	Medical Society	1963 to 1967
Ben W. Dawsey, D.V.M.	Gastonia	Gov. Terry Sanford	1963 to 1967
Joseph S. Hiatt, Jr., M.D.	Southern Pines	Medical Society	1965 to 1969
Howard Paul Steiger, M.D.	Charlotte Medical Society	Medical Society	1965 to 1969

18. Fill vacancy caused by death of Dr. Chas. R. Bugg.

ROSTER OF MEMBERS OF THE VARIOUS BOARDS OF MEDICAL EXAMINERS OF THE STATE OF NORTH CAROLINA

FIRST BOARD

James H. Dickson, Wilmington	1859-1866
Charles E. Johnson, Raleigh	1859-1866
Caleb Winslow, Hertford	1859-1866
Otis F. Manson, Townsville	1859-1866
William H. McKee, Raleigh	1859-1866
Christopher Happoldt, Morganton	1859-1866
J. Graham Tull, New Bern	1859-1866
Samuel T. Iredell, Secretary	1859-1866

SECOND BOARD

N. J. Pittman, Tarboro	1866-1872
E. Burke Haywood, Raleigh	1866-1872
R. H. Winborne, Edenton	1866-1872
S. S. Satchwell, Rocky Point	1866-1872
J. J. Summerell, Salisbury	1866-1872
R. B. Haywood, Raleigh	1866-1872
M. Whitehead, Salisbury	1866-1872
J. F. Shaffner, Salem	1866-1872
William Little, Secretary	1866-1872
Thomas F. Wood, Secretary, Wilmington	1867-1872

THIRD BOARD

Charles J. O'Hagan, Greenville	1872-1878
W. A. B. Norcom, Edenton	1872-1878
C. Tate Murphy, Clinton	1872-1878
George A. Foote, Warrenton	1872-1878
J. W. Jones, Tarboro	1872-1878
R. L. Payne, Lexington	1872-1878
Charles Duffy, Jr., Secretary, New Bern	1872-1878

FOURTH BOARD

Peter E. Hines, Raleigh	1878-1884
Thomas D. Haigh, Fayetteville	1878-1884
George L. Kirby, Goldsboro	1878-1884
Thomas F. Wood, Wilmington	1878-1884
Joseph Graham, Charlotte	1878-1884
Robert I. Hicks, Williamston ¹	1878-1880
Richard H. Lewis, Raleigh ²	1880-1884
Henry T. Bahnson, Secretary, Salem	1878-1884

FIFTH BOARD

William R. Wood, Scotland Neck	1884-1890
Augustus W. Knox, Raleigh	1884-1890
Francis Duffy, New Bern	1884-1890
Patrick L. Murphy, Morganton	1884-1890
Willis Alston, Littleton	1884-1890
J. A. Reagan, Weaverville	1884-1890
W. J. H. Bellamy, Secretary, Wilmington	1894-1890

SIXTH AND SEVENTH BOARDS³

R. L. Payne, Jr., Lexington	1890-1892
George W. Purefoy, Asheville	1890-1892
George G. Thomas, Wilmington	1890-1894
Robert S. Young, Concord	1890-1894
William H. Whitehead, Rocky Mount	1890-1896
George W. Long, Graham	1890-1896
L. J. Picot, Secretary, Littleton	1890-1896
Julian M. Baker, Tarboro	1892-1898
H. B. Weaver, Secretary, Asheville	1892-1898
J. M. Hays, Greensboro ⁴	1894-1897
Kemp P. Battle, Jr., Raleigh ⁵	1897-1900
Thomas S. Burbank, Wilmington ¹	1894-1898
Richard S. Whitehead, Chapel Hill ⁴	1896-1898
William H. H. Cobb, Goldsboro ⁶	1898-1900
J. Howell Way, Secretary, Waynesville ⁷	1898-1902
David T. Tayloe, Washington	1896-1902
Thomas E. Anderson, Sec., Statesville	1896-1902
Albert Anderson, Wilson ⁸	1896-1902
Edward C. Register, Charlotte ⁸	1898-1902
Thomas S. McMullan, Hertford ⁸	1900-1902
John C. Walton ⁸	1900-1902

EIGHTH BOARD

A. A. Kent, Lenoir	1902-1908
Charles O'H. Laughinghouse, Greenville	1902-1908
M. H. Fletcher, Asheville	1902-1908
James M. Parrott, Kinston	1902-1908
J. T. J. Battle, Greensboro	1902-1908
Frank H. Russell, Wilmington	1902-1908
George W. Pressly, Secretary, Charlotte ¹	1902-1906
G. T. Sikes, Secretary, Grissom ⁹	1906-1908

NINTH BOARD

Lewis B. McBrayer, Asheville	1908-1914
John C. Rodman, Washington	1908-1914
William W. McKenzie, Salisbury	1908-1914
Henry H. Dodson, Greensboro	1908-1914
John Bynum, Winston-Salem	1908-1914
J. L. Nicholson, Richlands	1908-1914
Benj. K. Hays, Secretary, Oxford	1908-1914

TENTH BOARD

Isaac M. Taylor, Morganton	1914-1920
John Q. Myers, Charlotte	1914-1920
Jacob F. Highsmith, Fayetteville	1914-1920
Martin L. Stevens, Asheville	1914-1920
Charles T. Harper, Wilmington ⁴	1914-1915
Edwin G. Moore, Elm City ¹⁰	1915-1920
John G. Blount, Washington ¹¹	1914-1920
Hubert A. Royster, Secretary, Raleigh	1914-1920

ELEVENTH BOARD

Lester A. Crowell, Lincolnton	1920-1926
William P. Holt, Duke	1920-1926
J. Gerald Murphy, Wilmington	1920-1926
Lucius N. Glenn, Gastonia	1920-1926
Clarence A. Shore, Raleigh	1920-1926
William M. Jones, Greensboro	1920-1926
Kemp P. B. Bonner, Sec., Morehead City	1920-1926

TWELFTH BOARD

Paul H. Ringer, Asheville	1926-1932
W. Houston Moore, Wilmington	1926-1932
T. W. M. Long, Roanoke Rapids	1926-1932
W. W. Dawson, Grifton ⁴	1926-1930
J. K. Pepper, Winston-Salem	1926-1932
Foy Roberson, Durham	1926-1932
John W. McConnell, Secretary, Davidson	1926-1932
David T. Tayloe, Jr., Washington ¹²	1930-1932

THIRTEENTH BOARD

Ben F. Royal, Morehead City	1932-1938
Benj. J. Lawrence, Secretary, Raleigh	1932-1938
F. Webb Griffith, Asheville	1932-1938
Hamilton W. McKay, Charlotte	1932-1938
J. W. Vernon, Morganton	1932-1938
W. H. Smith, Goldsboro	1932-1938
K. G. Averitt, Cedar Creek ⁴	1932-1936
Roscoe D. McMillan, Red Springs ¹³	1936-1938

FOURTEENTH BOARD

Karl B. Pace, Greenville	1938-1944
William M. Coppridge, Durham	1938-1944
Frank A. Sharpe, Greensboro	1938-1944
Lewis W. Elias, Asheville ⁴	1938-1943
J. Street Brewer, Roseboro	1938-1944
W. D. James, Secretary, Hamlet	1938-1944
L. A. Crowell, Jr., Lincolnton	1938-1944
John LaBruce Ward, Asheville ¹⁴	1943-1944

FIFTEENTH BOARD

C. W. Armstrong, Salisbury	1944-1950
Paul G. Parker, Erwin	1944-1950
M. D. Bonner, Jamestown	1944-1950
T. Leslie Lee, Kinston	1944-1950
Roy B. McKnight, Charlotte	1944-1950
M. A. Pittman, Wilson	1944-1950
Ivan M. Proctor, Secretary, Raleigh	1944-1950
James B. Bullitt, Chapel Hill ¹⁵	1949-1950
Paul F. Whitaker, Kinston ¹⁶	1950

SIXTEENTH BOARD

Amos N. Johnson, Garland	1950-1956
Heyward C. Thompson, Shelby	1950-1956
James P. Rousseau, Winston-Salem	1950-1956
Newsom P. Battle, Rocky Mount	1950-1956
Clyde R. Hedrick, Lenoir	1950-1956
L. Randolph Doffermyre, Dunn	1950-1956
G. Westbrook Murphy, Asheville ¹⁷	1955
Joseph J. Combs, Secretary, Raleigh	1950-1956

SEVENTEENTH BOARD

Carl Vann Tyner, M.D., Leaksville	1956-1962
Joseph John Combs, M.D., Raleigh	1956-1962
John Bascom Anderson, M.D., Asheville	1956-1962
Thomas Williams Baker, M.D., Charlotte	1956-1962
Edwin Albert Rasberry, Jr., M.D., Wilson	1956-1962
Thomas G. Thurston, M.D., Salisbury	1956-1962
Luther Randolph Doffermyre, M.D., Dunn	1956-1962

EIGHTEENTH BOARD¹⁸

Frank Edmondson, Jr., Asheboro, Pres.	1962-1964
Re-elected (6-yr. term)	1964-1970
Ralph G. Templeton, Lenoir ¹⁹	1962-1964
Re-elected (6-yr. term)	1964-1970
Joseph John Combs, Secretary, Raleigh	1962-1964
Re-elected (6-yr. term)	1966-1972
H. Lee Large, Jr., Charlotte	1962-1966
Re-elected (6-yr term)	1966-1972
James E. Davis, Durham	1962-1968
W. Boyd Owen, Waynesville	1962-1968
Clark Rodman, Washington	1962-1968
Vernon W. Taylor, Jr., M.D., Elkin ²⁰	1966-1970

1 Resigned before expiration of term.

2 Elected for unexpired term of Dr. Hicks.

3 In 1890 the Medical Society of the State of North Carolina adopted the plan of electing members of the Board in such a manner that the terms would expire at different intervals of two years. This practice was followed for twelve years, or until 1902, when the plan was abandoned; an equivalent of two terms of six years each. It is evident that the Society arranged to abandon the policy as early as 1898, as two members were elected for short terms, and two years later two other members were elected for still shorter terms. It is therefore impossible to separate the sixth and seventh Boards, since the membership was overlapping.

4 Died before the expiration of his term.

5 Elected to serve unexpired term of Dr. Hays.

6 Elected to serve the unexpired term of Dr. Burbank.

7 Elected to serve the unexpired term of Dr. Whitehead.

8 Elected for short term expiring in 1902.

9 Elected to serve the unexpired term of Dr. Pressly.

10 Elected to serve the unexpired term of Dr. Harper.

11 Died a few months before the expiration of his term; such a short time that the vacancy was not filled.

12 Elected to serve unexpired term of Dr. W. W. Dawson.

13 Elected to serve unexpired term of Dr. Averitt.

14 Elected to serve the unexpired term of Dr. Elias.

15 Elected to serve unexpired term of Dr. T. Leslie Lee.

16 Elected to serve unexpired term of Dr. Paul G. Parker.

17 Elected to serve unexpired term of Dr. James P. Rousseau.

18 In 1962 the Medical Society of the State of North Carolina adopted a plan for election members of the Board in such a manner that some of the terms would expire at intervals of two years, hence the varying terms of the first-selected board members.

19 Died before expiration of term.

20 Elected to serve unexpired term of Dr. Ralph P. Templeton.

MEDICAL AWARDS

MOORE COUNTY MEDICAL SOCIETY MEDAL

In 1927 the Moore County Medical Society established a fund, the interest from which is used to pay for a medal to be given for the best paper read at the State Society meeting each year. No one is eligible to receive this medal except Fellows of the Medical Society of the State of North Carolina in good standing; no invited guest is allowed to compete.

Each Section Chairman selected a committee of three to decide on the best paper written in their section. The winning papers are then turned over to the State Committee, who select the one to receive the medal. The following Fellows have been awarded this medal:

- 1928—Paul Pressly McCain, M.D. Sanatorium
"The Diagnosis and Significance of Juvenile Tuberculosis"
(From the Section on Pediatrics)
- 1929—A. B. Holmes, M.D. Fairmont
"The Treatment of Uremia"
(From the Section on Chemistry, Materia Medica and Therapeutics)
- 1930—C. T. Smith, M.D., and W. Bernard Kinlaw, M.D. Rocky Mount
"The Clinical Consideration of Anemia of Pregnancy and of Puerperium"
(From Section on Practice of Medicine)
- 1931—F. C. Smith, M.D. Charlotte
"Practical Value of Perimetry in Intracranial Conditions; Case Reports" (tumors, vascular disease, toxemia, syphilis and trauma)
(From Section on Eye, Ear, Nose and Throat)
- 1932—Charles I. Allen, M.D. Wadesboro
"An Improved Splint for Treating Fractures of the Lower Extremity Showing Reduction and Skeletal Distraction Attachments"
(From Section on Surgery)
- 1933—H. L. Sloan, M.D. Charlotte
"Some General Remarks about Cataract Surgery, With Report of 100 Consecutive Uncomplicated Cataract Operations"
(From Section on Ophthalmology and Otolaryngology)
- J. R. Adams, M.D. Charlotte
"Hypo-glycaemia in Children"
(From Section on Pediatrics)
- 1934—Fred E. Motley, M.D. Charlotte
"Complications of Mastoiditis with Special Reference to Septicemia"
(From Section on Ophthalmology and Otolaryngology)
- 1935—Arthur H. London, M.D. Durham
"The Composition of an Average Pediatrics Practice"
(From Section on Pediatrics)
- 1936—V. K. Hart, M.D. Charlotte
"Etiological and Therapeutic Aspects of Bronchiectasis with Clinical Observations on Bronchial Lavage by the Stitt Method"
(From Section on Ophthalmology and Otolaryngology)
- 1937—No award made.
- 1938—O. Hunter Jones, M.D. Charlotte
"Pelvic Architecture and Classification with its Practical Application"
(From Section on Gynecology and Obstetrics)
- 1939—Donnell B. Cobb, M.D. Goldsboro
"Vaginal Ureterolithotomy"
(From Section on Surgery)
- 1940—C. R. Monroe, M.D., C. D. Thomas, M.D., and C. L. Gray, M.D. Pinehurst
"Thoracoplasty and Apicolysis"
(From Section on Surgery)
- 1941—Walter R. Johnson, M.D. Asheville
"Is Diverticulitis of the Colon a Surgical Disease?"
(From Section on Practice of Medicine)
- 1942—E. P. Alyea, M.D. Durham
"Castration for Carcinoma of the Prostate Gland"
(From Section on Surgery)
- 1943—No award made.
- 1944—D. F. Milam, M.D. Chapel Hill
"Vitamin C Content of Some North Carolina Cooked Foods"
(From Section on Public Health and Education)
- 1945—No Meeting.
- 1946—E. C. Hamblen, M.D. Durham
"Some Aspects of Sex Endocrinology in General Practice"
(From Section on General Practice of Medicine and Surgery)
- 1947—W. L. Thomas, M.D. Durham
"Some Psychosomatic Problems in Gynecology"
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- 1951—John P. U. McLeod, M.D. Marshville
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"Humidification in Pediatrics"
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"Diagnosis and Management of Poisoning Due to Organic Phosphate Insecticides"
(From Section on Pediatrics)
- 1954—Paul Kimmelstiel, M.D. Charlotte
Roland T. Pixley, M.D. Charlotte
John Crawford, M.D. Charlotte
"Statistical Review of Twenty-two Thousand Cases Examined by Cervical Smears"
(From Section on Pathology)
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- 1958—John O. Lafferty, M.D.
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(From Section on Public Health & Education)
- 1960—William J. A. DeMaria, M.D. Durham
"Management of Childhood Nephrosis"
(From Section on Pediatrics)
- 1961—William W. Shingleton, M.D. Durham
"Some Recent Clinical and Experimental Advances Relative to Diseases of the Biliary Tracts and Pancreas"
(From Section on Surgery)
- 1962—Frank C. Greiss, Jr., M.D. Winston-Salem
"Inevitable, Incomplete and Septic Abortions"
(From Section on Obstetrics & Gynecology)
- 1963—No Awards.

1964—Christopher Columbus Fordham,
III, M.D. Chapel Hill
"Problems in the Diagnosis of Renal
Parenchyma Disease"
(From Section on General Practice of
Medicine)

1965—Archie Lipe Barringer, M.D. Mount Pleasant
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MALE"
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1952—Ronald Stephen, M.D., Senior Author;
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"The Evaluation of Methods of Pain Relief During
Labor and Delivery with Reference to Mother
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(From Section on Gynecology and Obstetrics)

1953—Ernest Craige, M.D. Chapel Hill
"The Prevention of Recurrences of Rheumatic
Fever"
(From the Section on Practice of Medicine)

1954—Richard L. Pearse, M.D. Durham
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"Obstetric Analgesia and Anesthesia"

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1955—Dirk Verhaeff, M.D. Huntersville
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"The Trends in Management of Tuberculosis in
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(From Section on Pediatrics)

1956—Benjamin A. Johnson, M.D. Durham
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Reference to Eczema Vaccinatum"
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Marie Baldwin, M.D. Asheville
Anne Sagberg, M.D. Asheville
R. Charman Carroll, M.D. Asheville
"Trends in the Development of an Open
Psychiatric Hospital"

(From Section on Neurology on Psychiatry)

1958—Madison S. Spach, M.D.
Jerome S. Harris, M.D.
"Congenital Heart Disease in Infancy"
(From Section on Pediatrics)

1959—Roy T. Parker, M.D. Durham
Harry W. Johnson, M.D. Durham
F. Bavard Carter, M.D. Durham
"Obstetric Shock"

(From Section on General Practice of Medicine)

1960—Courtney D. Egerton, M.D. Raleigh
Robert J. Ruark, M.D. Raleigh
"Continuous Caudal Analgesia in Private
Practice"

(From Section on Obstetrics & Gynecology)

1961—Kenneth D. Hall, M.D. Durham
"Post-Anesthetic Care of the Geriatric Patient"
(From Section on Anesthesiology)

1962—Jesse P. Chapman, Jr., M.D. Asheville
"Thoracic Trauma and Its Treatment"
(From Section on Orthopaedics and Traumatology)

1963—No Awards.

1964—Robert Stevenson Lackey, M.D. Charlotte
"Special Procedures in a Community Hospital"
(From Section on Radiology)

1965—No Awards.

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 "Tattooing the Cornea"
 (From Scientific Exhibits)
- 1953—Joseph E. Markee, M.D. Durham
 "Autonomic Nervous System"
 (Film from Audio-Visual Postgraduate Instructional Program)
- 1954—William H. Boyce, M.D. Winston-Salem
 Fred K. Garvey, M.D. Winston-Salem
 Charles M. Norfleet, M.D. Winston-Salem
 "Biocolloids of Urine in Health and in Calculous Disease"
 (From Scientific Exhibits)
- 1955—Caleb Young, M.D. Winston-Salem
 "Congenital Dislocation of the Hip"
 (A motion picture)
 (From Postgraduate Audio-Visual Program)
- 1956—C. R. Stephen, M.D. Durham
 R. C. Martin, M.D. Durham
 Bourgeois-Gavardin. Durham
 "Prophylaxis of Non-Hemolytic Transfusion Reactions: Value of Pyribenzamine"
 (From Section on Anesthesia)

- 1957—J. Leonard Goldner, M.D. Durham
 Mr. Bert Titus Durham
 "The Juvenile Amputee-Upper Extremity"
 (From Section on General Practice of Medicine)
- 1958—T. Franklin Williams, M.D.
 J. L. DeWalt, M.D.
 R. W. Winter, M.D.
 Charles H. Burnett, M.D.
 "Newer Diagnostic Criteria in Hyperparathyroidism"
 (From 1958 Scientific Exhibits)
- 1959—Albert G. Smith, M.D. Durham
 "Automation in the Clinical Chemistry Laboratory"
- 1960—Paul W. Sanger, M.D. Charlotte
 "Surgical Management of Deformities of the Anterior Chest"
 (From 1960 Scientific Exhibits)
- 1961—Robert Page Morehead, M.D. . . . Winston-Salem
 "Tumor Formation"
 (1961 Scientific Exhibits)
- 1962—Paul W. Sanger, M.D. Charlotte
 "Closure of Ventricular Septal Effects—Presentation of New Methods"
 (1962 Scientific Exhibits)
- 1963—No Awards.
- 1964—Joseph William Eades, M.D. Greensboro
 Hilliard Foster Seigler, M.D. Greensboro
 "Hand Rehabilitation Center" Chapel Hill
 (1964 Scientific Exhibits)
- 1965—Carl N. Patterson, M.D. Durham
 "PHYSIOLOGIC SEPTOPLASTY AND RHINOPLASTY"
 (From Section on Ophthalmology & Otolaryngology)



MEDICAL JOURNAL

PUBLISHED MONTHLY BY THE MEDICAL SOCIETY OF THE STATE OF NORTH CAROLINA

IN THIS ISSUE:

Radiofrequency Cordotomy for Intractable Pain

DAVID L. KELLY, JR., M.D. AND EBEN ALEXANDER, JR., M.D.

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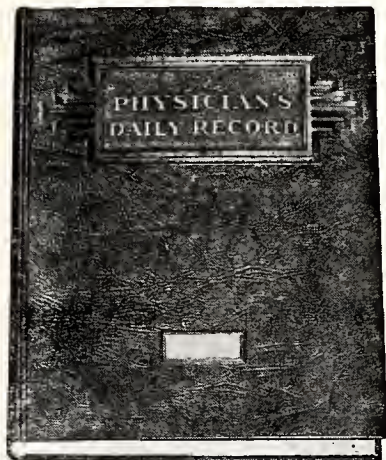
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VOLUME 27

OCTOBER, 1966

NUMBER 10

Radiofrequency Cordotomy for Intractable Pain

DAVID L. KELLY, JR., M.D., AND EBEN ALEXANDER, JR., M.D.

WINSTON-SALEM

With the continuing development and use of new chemotherapeutic agents, radical palliative surgical procedures, and more effective radiotherapy, great numbers of patients with cancers are living longer. Unfortunately, the increased longevity is often accompanied by pain and suffering. This places an additional responsibility on physicians to devise new methods of treating intractable pain.

The mechanisms of intractable pain with cancer can be divided into three broad categories: (1) skeletal involvement, from either direct invasion or hematogenous spread; (2) ulceration of superficial lesions that expose nerve endings; and (3) invasion, compression, or distortion of a sensory nerve, nerve root, or nerve plexus. When chemotherapy, radiotherapy, and surgical palliation are ineffective in relieving pain, neurosurgical procedures should be considered.

Two decisions must be made by the family physician and the neurosurgeon. The first is when to perform a pain-relieving procedure, and the second is what type of procedure to use.

When to Operate

The choice of *time* must be based upon the degree and distribution of pain, the type and extent of disease, the expected longevity, and the condition and attitude of the patient. These factors must be weighed against the discomfort, expense, morbidity, and mortality of the procedure itself. A common mistake

is to prolong treatment with some new combination of drugs or nonsurgical approach until the patient becomes either a hopeless narcotic addict or severely debilitated and close to death. Most neurosurgeons have felt that pain-relieving procedures were most useful with patients having a life expectancy of from 3 to 18 months. For shorter periods, large dosages of narcotics should suffice for the relief of suffering. For longer periods, the use of chemotherapy, hormones, and non-narcotic analgesic drugs should be exhaustively explored.

Choice of Procedure

The *type* of procedure used depends upon the type of malignancy and the severity, duration, and site of pain involved. The effectiveness of sensory root section for head and neck, thoracic, and abdominal pain is well established. Hypophysectomy with resulting hormonal suppression will give objective remission and relief of pain in from 40% to 60% of selected cases of breast and prostatic cancer. Peripheral nerve blocks with alcohol are effective for short-term relief of pain in elderly or debilitated patients with fairly localized lesions. Subarachnoid alcohol and phenol afford significant relief of lower extremity and perineal pain for variable periods of time in approximately 75% of selected patients. Frontal leukotomy with various modifications has limited palliative value, and should never be performed when a root or tract section would suffice. This procedure should be reserved for patients with generalized pain about the head or neck when other procedures are too formidable or when the pain of an inoperable lesion causes severe anxiety and depression.

From the Department of Surgery, Section on Neurosurgery, Bowman Gray School of Medicine of Wake Forest College, Winston-Salem, North Carolina.

Request for reprints to the Section on Neurosurgery, Department of Surgery, Bowman Gray School of Medicine of Wake Forest College, Winston-Salem 27103 (Dr. Kelly).

Open Surgical Cordotomy

Open surgical cordotomy has been the single most effective and applicable procedure for the relief of pain. The operation has long been in use,¹ but misapprehension as to its effects still remains among patients and some physicians. Significant weakness of the extremities is rarely produced and, if so, is transient. Since the sensations of touch and position are unimpaired, the patient is not left with a numb, useless extremity.

Open surgical cordotomy is based upon the well-defined anatomy of the spinal cord. It is a precise operation and must be performed with great care to achieve optimum results. It provides relief in 80% to 90% of patients with pain originating below the costal margin and in 50% to 75% of those with pain originating in the arms and upper part of the chest. Failures are usually the result of subsequent development of pain above the level of analgesia, improper selection of patients, or faulty technique.

A high thoracic (T1-T2) cordotomy is satisfactory for pain in the pelvis or legs, but a high cervical (C1-C2) cordotomy may be necessary for pain in the arms and chest. In general, if the pain is bilateral, the cordotomies should be staged seven to ten days apart, unless the patient already has appreciable motor or urinary bladder impairment.

Narcotic addiction plays a small role in the failure of this procedure. True drug addiction probably results from a psychogenic need for medication, which is usually lacking in a person with a definite organic basis for pain. It is often difficult to establish the presence of true addiction; patients who have received large doses of narcotics for weeks or months, if relieved of pain, may tolerate rapid withdrawal postoperatively without significant effects.

Percutaneous Cordotomy

Recently, important progress has been made in palliative surgery with the development of percutaneous cordotomy. The concept of this procedure should be credited to Mullan and his associates,² who were the first to use a radioactive-tipped needle. With the adoption of the radiofrequency generator to make the lesion, the technique has been

simplified and made safer.³ The refinement of the percutaneous approach, supplemented by increased anatomic knowledge of the pathways of pain (Fig. 1) and by experience

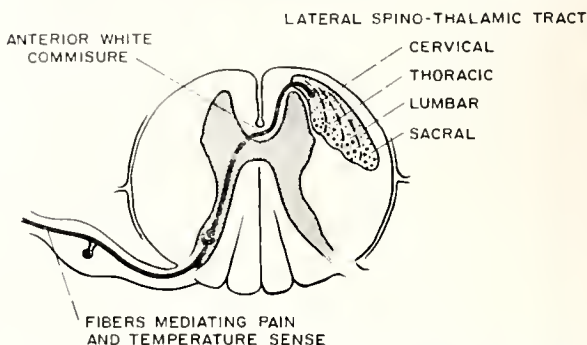


Fig. 1. Cross section of upper cervical spinal cord. Pain fibers enter through the posterior sensory root and terminate in the substantia gelatinosa of Rolandi. The axons of these cell bodies ascend 2 to 4 segments in the cord and then cross anteriorly to ascend in the lateral spinothalamic tract. There is lamination of these fibers with the sacral fibers posterior and lateral to the cervical fibers.

gained through the open surgical cordotomy, affords the neurosurgeon with the most acceptable operation to date for the relief of pain.

A number of advantages have been demonstrated: (1) The operation is safe and well tolerated by the patient; (2) the effects are immediate and can be evaluated during the procedure; (3) patients who cannot be subjected to a major surgical procedure may now be relieved of pain; (4) the problem of wound-healing in a debilitated patient is avoided; and (5) results are better than those of open surgical cordotomy.

Technique

The patient is first given a mild sedative since it is desirable to have a subject who is well relaxed but able to cooperate fully. The procedure is performed in the x-ray department with the patient in the supine position on a standard table. An air mattress is placed under the shoulders and body for comfort and elevation of the thorax. The head is supported by a small foam-rubber rest (Fig. 2).

The placement of the needle and electrode is monitored by x-ray. Standard anteroposterior and lateral radiographs of the cervical spine are suitable, but the procedure can be performed more quickly with the use of rap-



Fig. 2. Patient on x-ray table with overhead image amplifier and television monitor.

id-processing Polaroid film, the image amplifier, or both. The skin of the upper cervical area is then prepared, and the skin, fascia, and musculature are infiltrated in the (C1-C2) region with a 1% concentration of procaine. An 18-gauge, thin-walled spinal needle is introduced parallel to the x-ray table, through the lateral cervical musculature between the laminal arches of C1 and C2. Care is taken to direct the needle to the anterior one-third of the spinal canal to avoid contact with the cervical spinal cord. As the dura mater is punctured, the stylet is removed and cerebrospinal fluid is exchanged for 5 to 10 ml of air (Fig. 3). A lateral roentgenogram then reveals the anterior limits of the spinal cord and the position of the tip of the needle in relation to it (Fig. 4). The hub of the needle is attached to the stereotaxic manipulator for further positioning. It is possible to change the angle of the needle by raising or lowering the hub, which moves the tip in the opposite direction, with the soft tissues of the neck acting as a fulcrum. In the lateral view, the tip of the needle should be 1 to 2 mm posterior to the anterior limit of the spinal cord as outlined by the air shadow.

In the anteroposterior view, the shadow of the spinal cord cannot be seen, but the spinal cord at the C2 level is approximately as wide as the odontoid, which can be seen quite easily. The tip of the needle in the sagittal plane should be at the lateral edge of the dens (Fig. 5).

With the tip of the needle in the proper position, a stainless-steel electrode is passed

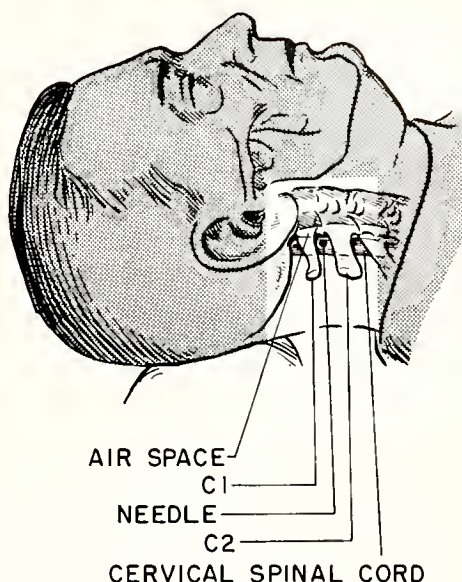


Fig. 3. Drawing showing relationship of needle to C1-C2, spinal cord, and air-filled subarachnoid space.



Fig. 4. Lateral roentgenogram showing light air shadow over dark spinal cord. Tip of needle directed 1 to 2 mm posterior to anterior limits of cord.

through the needle 4 mm. distal to its tip. The electrode is insulated from the needle by polyethylene tubing to a point 2 mm distal to the tip of the needle, thus leaving 2 mm of exposed electrode to pierce the cord (Fig. 6). The patient usually experiences a slight transient pain behind the left ear at this point.

The radiofrequency generator is then connected, the active lead going to the stainless-



Fig. 5. Anteroposterior roentgenogram showing tip of needle in line with lateral margin of odontoid. Small electrode can be seen projecting through needle into cord.

steel electrode and the inactive lead to the 18-gauge needle. The radiofrequency generator is ideally suited for this procedure. The spinal cord conducts radiofrequency poorly. The application of a radiofrequency voltage to the electrode causes current to flow, which in turn heats the area around the electrode. The heating rate falls off at about the inverse fourth power from the electrode's tip, confining a high temperature to a relatively small area. The critical temperature for permanent destruction of a small area in the spinal cord is approximately 45 degrees C. With temperatures in the range of 100 degrees C, as produced by standard cautery units, there is intense local damage at the electrode's tip, resulting in a coagulum coating the electrode. The lesions produced in the lateral spinothalamic tract are in the range of 2 to 4 mm in size.

The patient is given progressively increasing radiofrequency voltage for lengthening periods of time—5, 10, and 15 seconds (Fig. 7). The contralateral foot and leg are tested for analgesia to pinprick. The analgesic level is raised by increasing either the voltage or the duration of current flow to the desired level, depending upon the site of the pain. Usually the level is carried 4 to 5 dermatomal

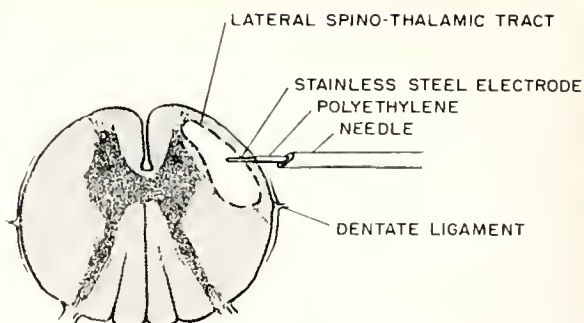


Fig. 6. Drawing of cross section of cervical cord showing the relationship of needle, insulated and noninsulated parts of electrode.

segments higher than the level of pain to allow for a possible fall in the level postoperatively. The ipsilateral arm and leg are examined for weakness after each increment of current. The entire procedure lasts from 35 to 90 minutes.

Results

Our experience with percutaneous cordotomy consists of 21 operations on 17 patients performed over the past 10 months. Fourteen patients had intractable pain associated with cancer. The remaining 3 patients had benign diseases with severe, prolonged pain which could not be relieved by other means. Four patients have undergone bilateral operations, staged seven to ten days apart, because of bilateral disease and pain.

All except one of the patients experienced



Fig. 7. Photograph of patient with needle and electrode in place. Radiofrequency generator is on left and leads have been attached to both electrode and needle.

immediate relief of pain. This patient underwent a second operation which afforded temporary relief, but failed to achieve an analgesic level. Another operation has not yet been performed.

The follow-up period in this series is short, ranging from one to ten months. Four patients have died from cancer, but they remained free of pain in the treated area.

The procedure is not unduly painful. There is a burning sensation behind the ear when the current is given, probably caused by heating of the C2 posterior root. This sensation subsides quickly and without persistent numbness. Some patients have a mild, transient headache from the drainage of cerebrospinal fluid and the instillation of air.

No deaths have been associated with the procedure in our cases. Six patients experienced mild weakness of the ipsilateral leg, lasting only two to seven days and often described as a "rubbery" feeling rather than true weakness. Five patients have had transient difficulty with micturition, but all five had previously had similar problems associated with such conditions as tumors involving the sacral plexus and abdominoperineal resection.

The hospital stay is short, averaging three to four days. Several patients have returned home the following day. When bilateral procedures were performed the operations were staged seven to ten days apart. The second procedure may or may not be done on the same hospital admission, depending upon the degree of pain and the patient's general condition.

Discussion

A neurosurgical pain-relieving procedure is now available which has altered and no doubt will radically alter the surgical treatment of intractable pain from cancer and many chronic benign diseases. The objective is the same as that of the tried-and-proved open surgical cordotomy—the destruction of the lateral spinothalamic tract on the side opposite to the site of the pain. It should be considered as seriously as the older procedure, despite the mild side effects and the ease of performance.

The procedure is applicable to the patient with terminal cancer who, because of general debility or metastatic pulmonary lesions, cannot tolerate a major operation requiring general anesthesia. The patient has only to be alert enough to cooperate during the procedure and to be able to lie in the supine position. Even with the most severely ill patients, the mortality has been negligible.

The problem of wound healing is avoided, a serious consideration with open surgical cordotomy because of the often encountered anemias and protein and other deficiencies. The seven- to ten-day period of pain and soreness in the operative site is likewise eliminated. The patient is examined repeatedly during the procedure to prevent the creation of too large a lesion. The desired analgesia is produced, obviating a repeat procedure. As yet, the analgesic levels have not fallen postoperatively as they do after surgical cordotomy, though it should be remembered that the follow-up has been relatively short.

The morbidity in our patients has been transient and mild, much less than with open cordotomy or chemical rhizotomy. Position and vibratory sensation and touch are not impaired. A positive Babinski sign has not been observed. The explanation of this improvement over the already exacting surgical cordotomy probably is (1) the degree of control over the size of the radiofrequency lesion, (2) the more precise placement of the lesion, and (3) a conscious, cooperative subject to examine for evaluation of the results of the operation.

Summary

The causes of intractable pain secondary to malignancies and the indications for pain-relieving neurosurgical procedures are discussed. The technique of a new operation, the percutaneous cordotomy, is described.

The results indicate that at present percutaneous spinal cordotomy is the safest, most effective, and most widely applicable neurosurgical method of relieving pain. The selection of patients can now be broadened to include those with chronic benign painful disease and those suffering from terminal cancer.

The original drawings (Figs. 1, 3, and 6) were made by Mr. George C. Lynch, professor of medical illustrations of the Bowman Gray School of Medicine of Wake Forest College.

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"Hysterical" Swallowing Difficulties Caused by Anomalous Right Subclavian Artery

A Report of Nine Cases

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CHARLOTTE

There are few physicians who have not been haunted by nervous, young people bitterly complaining of "tightness in the throat," choking sensations, and swallowing difficulties. Because of the functional nature of these symptoms, the condition was properly called "globus hystericus."

The majority of these patients truly lack any objective basis for their complaints. However, it is not to be forgotten that in 1787 an anomaly of the right subclavian artery was suitably called *dysphagia lusoria* (jest of nature) by Bayford¹. This may play a lurid trick on patient and physician alike. We are here presenting our experiences with nine patients who had been treated as neurotics for years until further studies revealed that they had true esophageal compression caused by an anomalous right subclavian artery.

Embryologically, the "arteria lusoria" represents an abnormality of the distal descending portion of the fourth right aortic arch.² This artery arises as the fourth branch of the otherwise normal thoracic aorta; it

passes behind the esophagus and there occupies the position of the right subclavian artery. In about 20% of the cases there are variations in this course; the arteria lusoria may completely encircle the trachea and the esophagus,¹⁰ or it may pass between these two organs.⁵ (Fig. 1).

Clinical Picture

Eight of our nine patients were women and only one a man; their ages ranged from 21 to 38 years. Two patients had been symptomatic since childhood; the others began having swallowing difficulties during the teens or early adulthood. Six patients had had symptoms for more than three years.

The *common complaint* was dysphagia in all cases. It was described as a feeling of temporary arrest of bolus of food beneath the manubrium sterni. Three patients also had difficulty in swallowing liquids—especially when swallowing rapidly liquids that were too hot or cold. Three patients had respiratory symptoms consisting of wheezing, exertional dyspnea, and a dry nonproductive cough.

Seemingly none suffered from inanition or complained of weight loss. However, they were quite unhappy and frustrated because of their unexplained, chronic difficulties in swallowing. This led to disabling worry and depression. Eight of the nine patients had been repeatedly told by physicians that

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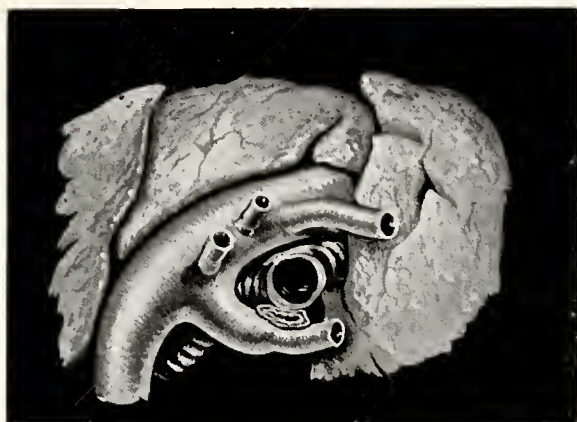


Fig. 1. The anatomic relationship of the arteria lusoria to the mediastinal structures as viewed from above.

their symptoms were "caused by nerves," and all had received tranquilizers or sedatives. Three patients were treated or were seen by psychiatrists, and one patient was psychoanalyzed for a period of six months because of "swallowing difficulties of psychic origin."

Physical examination of the nine patients failed to reveal anything abnormal which could be attributed to the diagnosis of this anomaly. The pulses were equal in both arms and there was no difference in blood pressure between the two upper extremities. Bruits over the major arteries of the neck and shoulder girdle were absent, and the pulse wave reached the radial arteries at the same time.

The most informative of all diagnostic aids was the *roentgenologic examination*. Barium swallow (if perfectly performed) outlined not only the nature but also the localization of arteria lusoria. The lateral or oblique views show a small caliber defect of the posterior wall of the esophagus at the level of the third or fourth thoracic vertebra.

An anteroposterior view shows this indentation running upward the patient's right. There is usually little or no ballooning of the proximal esophagus (Fig. 2). A filling defect on the anterior aspect of the esophagram is seen if the anomaly is located between the esophagus and the trachea. It must be emphasized, however, that the esophagus should be studied not only in the posteroanterior views but also in the oblique and lateral

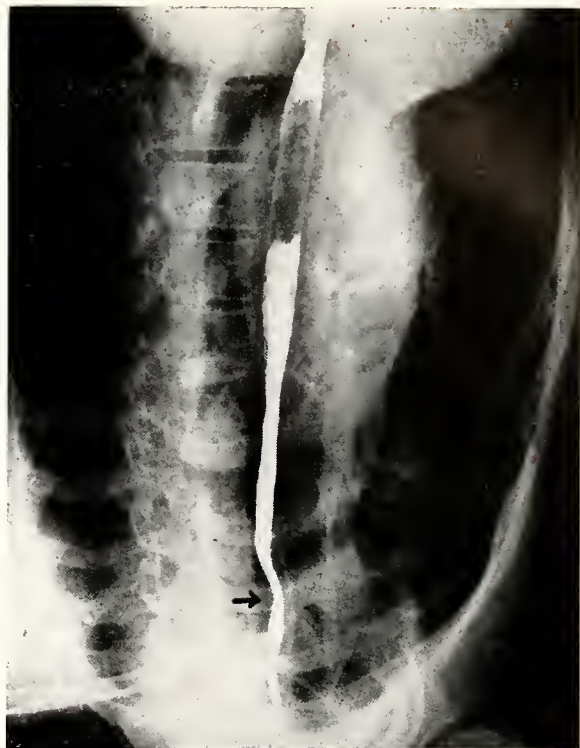


Fig. 2. Barium swallow esophagogram in the left anterior oblique view. The impression on the posterior aspect (arrow) is plainly visible.

views, because in the former (especially if the esophagus contains too much barium), the indentation will not be seen. The failure to examine multiple projections of the esophagus may explain the fact that results of previous x-ray studies of the esophagus had been "negative" in four of our patients.

We confirmed the presence of the arteria lusoria by angiography, though this is considered unnecessary by several authors^{3, 4, 6}. The reason for doing so is multiple:

In most cases the presence of the arteria lusoria could be established by simple x-ray studies of the esophagus. However, we are quite hesitant to base the diagnosis and a possible decision to operate on only a small indentation on the barium-filled esophagus. Catheter aortography is highly informative and bears a low risk if performed with caution and experience. It not only proves the presence of an anomalous right subclavian artery, but it helps to differentiate this abnormality from other forms of "vascular rings" such as a double aortic arch, which may produce similar clinical and x-ray signs.



Fig. 3. Catheter aortogram showing the aberrant right subclavian artery (arrow) arising from the distal aortic arch.

The right-sided approach commonly used for the surgical treatment of dysphagia lusoria is inadequate to cope with most of these anomalies.

Another reason to use angiography in dysphagia lusoria is that if there is one vascular anomaly, the likelihood of associated abnormalities is increased, and a detailed study of the origin and course of *all* major arteries of the thoracic inlet is highly advisable. Accidental ligation of either carotid artery, which may arise with the arteria lusoria, may lead to most undesirable consequences.

The angiographic examination is carried out by the percutaneous, transfemoral, catheter technique. This method involves practically no discomfort for the patient, allows repeated contrast studies in different projections, and gives an excellent visualization of the aortic arch and its branches (Fig. 3). An added advantage of this method is that it allows selective catheterization—and thus



Fig. 4. Catheter angiogram of the arteria lusoria. The anomalous artery arises in the left hemithorax, on the distal posterior aspect of the aortic arch.

better visualization—of the individual arteries (Fig. 4).

Esophagoscopy may reveal the presence of esophageal compression by a pulsatile mass, thus indicating the presence of the arteria lusoria. This sign, however, is present in only about 40% of the cases⁶ and therefore has only a limited value in the diagnosis of this condition.

Treatment

The treatment of the symptomatic arteria lusoria is surgical. The operation itself is quite simple: Through a right thoracotomy incision the anomalous artery is located in the posterior mediastinum. It is carefully dissected off the posterior wall of the esophagus, double-ligated, and divided close to its origin. There are always sufficient collateral vessels^{4, 9} to provide an adequate blood supply to the right arm.

The theoretical danger of this procedure is that the circulation to the right arm may become inadequate or a "subclavian steal" syn-



Fig. 5. Operative treatment of dysphagia lusoria. On picture A the aberrant artery is located posterior to the esophagus. On picture B the artery is dissected free and divided between double ligatures.

drome^s can develop. As far as we know, such complications have not been reported in several hundred successfully treated cases of dysphagia lusoria. These dangers should be kept in mind, however, and in elderly, arteriosclerotic patients an anastomosis between the distal end of the divided anomalous and the ascending aorta should be given preference to simple ligation and division of the anomalous artery.

Ligation and division of the arteria lusoria was carried out in all nine patients. There was no mortality in this series, and the recovery of all patients was smooth and free of complications. The average stay in the hospital following the operation was eight days. Eight of the nine patients are now symptom free. One patient continues to have moderate difficulties in swallowing.

Summary

Esophageal compression by an anomalous right subclavian artery (dysphagia lusoria) may remain undiagnosed and treated as a nervous disorder, or "hysterical" dysphagia.

On the basis of nine cases, the clinical picture and surgical treatment of dysphagia lusoria is presented. Eight patients became asymptomatic and one improved significantly.

All nine patients had been treated previously by sedatives and tranquilizers, eight were told that their difficulties were caused by "nerves," and three received psychiatric care before the true nature of their diseases was established.

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Aneurysm of Right-sided Thoracic Aorta

Resection and Graft with Aid of Partial By-pass

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The resection and graft replacement of aortic aneurysm is so well established that a review of the literature is not warranted, especially with a single case report.

The present case is reported because of the unusual nature of the aneurysm in a right-sided aorta, and also in order to demonstrate an interesting complication of angiocardiology.

Case Report

A 54 year old white man was admitted to Charlotte Memorial Hospital on November 4, 1964, complaining of tightness in his chest and choking sensations of two weeks' duration. His past history showed that he was hospitalized in 1948 for arthritis. Reaction to a blood Kahn test at that time was 4 plus, and he was given penicillin and Mapharsan. A chest x-ray on June 18, 1960 indicated a right aortic arch which was somewhat tortuous (Fig. 1). Admission examination disclosed a well developed heavy man who appeared healthy. His blood pressure was 140 systolic, 90 diastolic in both arms. The heart rhythm was regular and no murmurs were heard. The general physical examination was unremarkable. A serologic test for syphilis was again positive. X-ray examination of the chest revealed the right-sided aorta, and also a mass involving the lower portion of the descending aorta (Fig. 2).

On November 5, 1964, the patient was taken to the cardiac laboratory where a percutaneous, retrograde right femoral catheterization was done with the patient under local anesthesia. The catheter tip was repeatedly hung-up in the lower portion of what appeared to be an aneurysm in the thoracic aorta. Since the catheter could not be advanced further, 40 cc of Conray-400 was injected with the pressure injector, and rapid serial roent-

genograms were taken. The lower half of an aneurysm in the descending aorta was visualized just above the diaphragm (Fig. 3). The retrograde flow of dye was not sufficient to show the upper portion of the lesion.

In order to obtain better visualization of the aneurysm, catheterization of the right side of the heart was done on November 7, 1964, with advancement of the catheter tip into the right ventricle. Forty cubic centimeters of Conray-400 was injected through the catheter with the pressure injector and serial roentgenograms were taken. The patient immediately complained of severe substernal pain and became sweaty. His blood pressure fell temporarily to 90/60 but promptly returned to normal. The severe



Fig. 1. Routine chest roentgenogram made June 18, 1960, four and one-half years before aneurysm was discovered. A rather tortuous right-sided aortic arch is present.

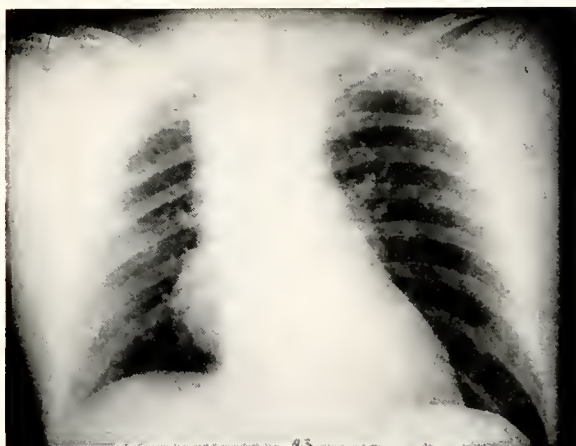


Fig. 2. Chest roentgenogram made June 5, 1964, reveals a mass involving the lower portion of the thoracic aorta.

pain lasted only a minute or two, diminishing to mild substernal discomfort. His clinical condition became stable by the time the x-rays were developed. The films showed intrapericardial distribution of the dye (Fig. 4). Since the patient's condition stabilized so promptly, he was returned to his room

for observation, where he remained in good condition.

Two days later, on November 9, 1964, the patient was carried to the operating room for resection of the aneurysm. Under general endotracheal anesthesia, in the supine position with his thorax rotated 45 degrees to the left, the patient was prepared for partial cardiac by-pass. Small polyethylene intracaths were inserted into his right femoral artery and saphenous vein for continuous pressure monitoring. A right anterolateral thoracotomy was done through the third intercostal space, and the sternum was divided transversely. The pericardium was opened longitudinally, yielding only 5 cc of clear serous fluid. There was no evidence of inflammation or blood from the intrapericardial injection two days previously. The right-sided aorta was noted and also a large saccular aneurysm extending from 10 cm. above the diaphragm to within 1 cm. of the diaphragm. The patient was heparinized, using



Fig. 3. Transfemoral retrograde aortogram obtained Nov. 5, 1964. The aneurysm of the right-sided aorta is incompletely filled owing to repeated curling of the catheter in the lower part of the aneurysm.



Fig. 44. Roentgenogram taken Nov. 7, 1964, showing pericardial extravasation of Conray-400 which was injected with pressure injector through a cardiac catheter in the right ventricle.

2.5 mg/Kg of body weight. The interatrial groove was dissected and a large outflow cannula inserted through a stab wound in the left atrium. A purse-string suture about the cannula gave prompt hemostasis. The left femoral artery was cannulated with a No. 14 plastic tube. Partial by-pass was started, with the left atrial cannula draining into a 500 cc venous reservoir by gravity. The blood was pumped from this reservoir directly back to the left femoral artery. Use of an oxygenator, of course, was not necessary.

The aorta was cross-clamped above and below the aneurysm, and the intercostal arteries from the aneurysm were ligated and divided. The aneurysm was opened longitudinally and the multi-laminated clots "skinned-out" along with most of the media, leaving the adventitia for later reinforcement of the graft. A few remaining intercostal arteries were over-sewn from the inside of the aneurysm. The aorta was divided just proximal and distal to the aneurysm. A No. 25 knitted Dacron graft, 10 cm. in length, was used to bridge the gap. The two anastomoses were effected, using 3-0 Mersilene continuous sutures. The adventitia from the aneurysm was wrapped about the graft and sewn in place for reinforcement. The distal and proximal aortic clamps were released, the heart functioned well, and the by-pass was stopped. As the graft was hemostatic, the cannula was removed and the patient's chest closed with under-water drainage. The heparin was neutralized with protamine sulfate, 2 mg/Kg of body weight. Pathologic examination of the resected specimen showed an aneurysm measuring 8 x 4 x 1.5 cm, with extensive mural thrombi. No evidence of syphilis was noted.

The patient's condition remained stable for the first two days. Urinary output was excellent. Two days after operation tachycardia of 180 minute developed. He was digitalized, but two days later (the fourth postoperative day) auricular fibrillation was noted. Direct current cardioversion resulted in a normal rhythm at a rate of 80-90, with a blood pressure of 120/90. The cardiac rhy-

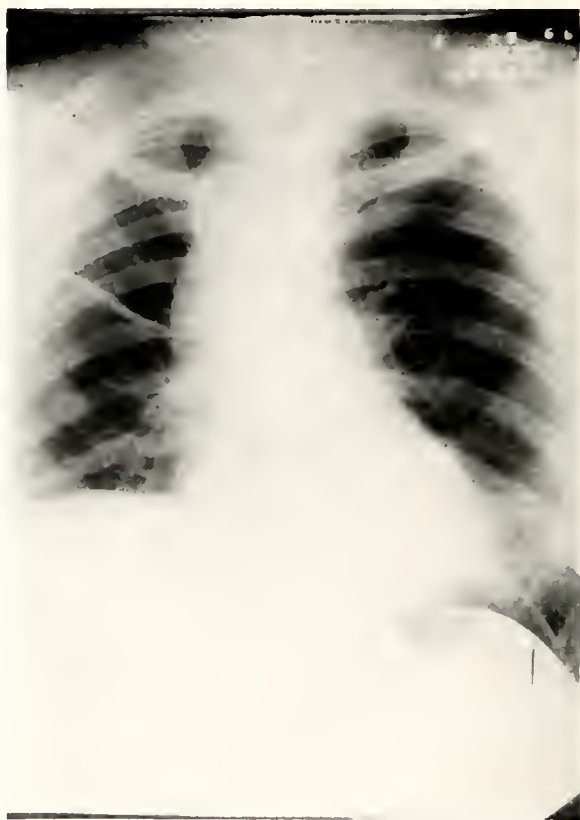


Fig. 5. Chest roentgenogram taken April 15, 1966, 17 months after resection and graft of aneurysm.

thm remained regular thereafter and the patient was discharged November 30, 1964.

A few weeks after discharge the patient returned to his usual heavy work in an upholstery operation. He was seen April 15, 1966, at which time x-ray examination of his chest showed no recurrence of his aneurysm (Fig. 5).

Discussion

The two unusual features of this case were the presence of an aneurysm in a right thoracic aorta and the extravasation of dye into the pericardial sac. The right-sided aorta presented no problems, although cannulation of the left atrium was not as easily accomplished as when approached through the left thorax.

The extravasation of dye produced transient pain and a drop in blood pressure. Two days later inspection of the pericardial space showed no blood or inflammatory reaction.

Pathophysiology of Chronic Bronchitis and Emphysema

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Chronic bronchitis can be defined as a condition in which excessive amounts of mucus are secreted into the bronchi. Emphysema is characterized by an increase in size of the airspaces distal to the terminal bronchioles as a result of tissue destruction.¹ Most patients with emphysema have chronic bronchitis, and patients with chronic bronchitis frequently develop emphysema. For this reason it is convenient to consider chronic bronchitis and emphysema as a broad clinical entity without necessarily implying a similar etiology.

It is the purpose of this presentation to discuss some aspects of the pathophysiology of this disease, in particular the impairment in gas exchange between the patient and his environment. Initially, impaired gas exchange is manifest only during exercise, but eventually it may lead to respiratory failure—that is, inadequate tissue oxygenation and elimination of carbon dioxide at rest.

Typically, an emphysematous patient has an increase in functional residual capacity, residual volume, and total lung capacity, and a decrease in inspiratory and expiratory reserve volume. The changes in lung volume found in emphysema can be explained in terms of diminished elastic recoil of the lung, which normally tends to decrease the volume of the thoracic cage, and of trapping of air due to expiratory air-flow obstruction. Except for the residual volume—which requires indirect measurement by means of a gas dilution method—lung volumes can be measured directly with a spirometer. Diminished elasticity of the lung is revealed by a decreased subatmospheric pressure in the pleural space, which can be measured with an intraesophageal balloon.²

The resistance to flow of air through the tracheobronchial tree is greater than normal

in patients with chronic bronchitis and emphysema. The effects of increased airway resistance are revealed by the spirogram, obtained with a recording spirometer. Increased resistance to airflow is most pronounced during expiration, since the bronchi dilate during inspiration as a result of radial traction on the bronchial wall transmitted from the expanding chest through collagenous and elastic fibers.³

Increased airway resistance may be caused by accumulation of mucus in the bronchial lumen, inflammatory thickening of the bronchial mucosa, contraction of the smooth-muscle fibers in the bronchial wall, bronchial collapse due to loss of cartilaginous support in the wall, or a combination of these factors. Since expiration of equal volumes of air requires more time in a patient with chronic bronchitis and emphysema than in a normal person, the total volume of air that can be inhaled and exhaled per minute, known as the maximum voluntary ventilation, is less than normal. Likewise, the one-second vital capacity and maximum mid-expiratory flow rate, two useful pulmonary function tests, are lower than normal in patients with chronic bronchitis and emphysema.

The delicate balance between ventilation and perfusion of the lungs is usually disrupted in patients with chronic bronchitis and emphysema. Equilibrium exists between end-capillary and alveolar oxygen tension in each individual alveolus if diffusion across the alveolar wall is not impaired, but the oxygen tension in mixed alveolar air is higher than the oxygen partial pressure in mixed pulmonary venous blood if blood-flow and air-flow are not evenly distributed over the myriad of alveoli in the lung.⁴ Uneven ventilation and perfusion of the lungs also results in differences between the partial pressures of carbon dioxide in mixed alveolar air and pulmonary venous blood. The differences between arterial and mixed alveolar partial pressures resulting from uneven ventilation

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and perfusion are, as a rule, greater for oxygen than for carbon dioxide, owing to the different shape of the blood oxygen and carbon dioxide dissociation curves.

Differences between oxygen and carbon dioxide tensions in arterial blood and mixed alveolar air can be expressed in terms of respiratory dead space defined as the actual or virtual volume of exhaled air having the same gas composition as inhaled air. Total respiratory dead space, usually referred to as physiologic dead space, consists of anatomic dead space, caused by the absence of gas exchange in the conducting airways, and distribution dead space, usually referred to as alveolar dead space, which results from the unequal ventilation and perfusion of different lung areas. Venous admixture, caused by anatomic right-to-left shunts, and ventilation of nonperfused lung areas are considered extreme cases of ventilation-perfusion disturbance.

The effect of alveolar-arterial gas tension differences may be expressed in an alveolar dead space equation derived from the Bohr equation:

$$V_{D_{\text{alv}}} = (V_T - V_{D_{\text{anat.}}}) \cdot \frac{(P_{A_x} - P_{a_x})}{(P_{I_x} - P_{a_x})}$$

When the difference between arterial and mixed alveolar gas tensions equals zero, alveolar dead space equals zero, and physiologic dead space equals anatomic dead space. The anatomic dead space is not significantly greater than normal in chronic bronchitis and emphysema.⁵ Consequently, an increased physiologic dead space reflects ventilation-perfusion or diffusion disturbances.

Recently, we have determined the oxygen and carbon dioxide physiologic dead spaces in a series of patients with chronic bronchitis and emphysema. Inspired, mixed expired, and arterial oxygen and carbon dioxide tensions were measured, and the physiologic dead space for oxygen and carbon dioxide was computed by means of the Bohr equation. Characteristically, the vital capacity and maximum voluntary ventilation were markedly decreased in these patients, but to varying degrees. Ventilation-perfusion disturbances resulted in increased physiologic

dead spaces, so that a large fraction of the already restricted minute ventilation was wasted, more so for oxygen than for carbon dioxide. Some patients appeared to be compensating for a large oxygen alveolar dead space by increasing their minute volume. This resulted in hyperventilation as far as carbon dioxide is concerned, since the carbon dioxide physiologic dead space was less than the total dead space for oxygen. These patients had lower than normal arterial carbon dioxide tensions.

Ventilation of the lungs of other patients was impaired mechanically to such an extent that they could no longer compensate for the increase in physiologic dead space. Effective ventilation was inadequate for carbon dioxide as well as for oxygen, as reflected by a subnormal arterial oxygen tension and an increased arterial carbon dioxide tension. Any increase in airway resistance or ventilation-perfusion disturbance as a result of infection or accumulation of bronchial secretions could be rapidly fatal in such patients.

Summary

In patients with chronic bronchitis and emphysema, ventilation of the lungs is mechanically restricted and functionally less effective due to an increase in physiologic dead space.

Since physiologic dead space is greater for oxygen than for carbon dioxide, hypoventilation for oxygen can coexist with hyperventilation for carbon dioxide. This accounts for the fact that the partial pressure of both oxygen and carbon dioxide may be less than normal in the arterial blood of patients with chronic bronchitis and emphysema. An increase in arterial carbon dioxide tension precedes the onset of respiratory failure.

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Neuroleptanalgesia: A Review

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June 18, 1966, marked the thirty-second anniversary of the first use of sodium thiopental, by Dr. John S. Lundy at the Mayo Clinic.¹ In January, 1942, Drs. Harold Griffith and Enid Johnson of Montreal first used curare to produce muscular relaxation during surgical anesthesia.² In September, 1956, Dr. Michael Johnstone, the British anesthesiologist, reported the first experiences with halothane.³

Three decades, three countries, three contributions: each profoundly altering general anesthesia as the patient experiences it, the surgeon "uses" it, and the anesthetist administers and controls it. What does the present decade promise?

Components of Anesthesia

Heretofore general anesthesia has consisted of three components: (1) hypnosis, (2) analgesia, and (3) muscle relaxation. To these can now be added a fourth—homeostatic control and stabilization.

The homeostatic mechanism has survival value for the individual and therefore for the species. Yet, paradoxically, during stresses that exhaust or override the corrective reflexes, previously life-preserving responses become life-threatening. Think of classical "shock"; of outpoured catecholamines driving a flagging myocardium, constricting arterioles, capillaries, and venules. Organ perfusion, the very reason for circulation, suffers. The accumulation of acid catabolites and the opening of pulmonary arteriovenous shunts may compound the damage by adding metabolic and respiratory acidosis to hypoxemia.

All currently used potent inhalation and intravenous anesthetics depress the myocar-

dium. Most of these agents can increase myocardial irritability or sensitivity to catecholamines.

The problem of vomiting and aspiration is ever present during the induction, maintenance, and recovery phases of anesthesia. Some emergencies simply cannot wait the mythical and "magic" four hours required for emptying the stomach. Regional or spinal techniques may not always be suitable, available, or acceptable. Fires and explosions are mercifully rare, but catastrophic when they occur. From these reflections we must conclude that as good as our present techniques are, there is room for improvement.

Early Experiences

Shortly after the appearance of the British report on halothane in 1956, this now familiar agent was being investigated and written about on our side of the Atlantic. Three years later, again in Europe, two Belgian anesthetists, DeCastro and Mundeleer, published papers on "Anesthesia without Barbiturates—Neuroleptanalgesia."^{4,5}

The terms "neurolept," "neuroleptosis," "neuroleptic" were first used in 1955 by the French psychiatrist, Jean Delay.⁶ Neuroleptosis plus analgesia equals neuroleptanalgesia (NLA). In anesthetic parlance neuroleptosis or the neuroleptic state is characterized by:

1. Disconnection — mental withdrawal from the immediate situation
2. Hypomotility—a disinclination to move
3. Homeostatic stabilization by blockade of alpha-adrenergic receptors
4. A potent antiemetic effect.

The first American publication relating to an early trial of neuroleptanalgesic drugs appeared in 1963.⁷ Since the European introduction and the first American trials of these agents, they have been constantly studied and improved. In Europe and South America clinical trials have led to regular clinical use. In this country, some 80 hospitals and medical centers have conducted clinical trials of

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NLA, including several in this state. More than 5,000 cases from throughout the nation have been tabulated.

Because anesthesia involves so much more than drugs, new and old, and because neuroleptanalgesia in particular depends upon the skill and understanding of the anesthesiologist, now would seem a good time to appraise the usefulness and potentiality of this relatively new concept and technique. Each doctor must evaluate the new drugs and techniques for himself, drawing on his knowledge of pharmacology, the experiences of other physicians, and his own clinical observations.

Neuroleptic Agents

One of the drugs used in neuroleptanalgesia is droperidol.⁸ Chemically, it is a butyrophenone and represents a new compound unrelated to the barbiturates, phenothiazines, antihistamines, or tranquilizers. Droperidol produces homeostatic stabilization — the fourth component of general anesthesia—by its peripheral action on the alpha-adrenergic receptor sites. The stimulation of these sites by catecholamines leads to vasoconstriction. If they are blocked, vasoconstriction does not occur or is greatly reduced. Peripheral resistance is decreased, the blood pressure reduced, and the work load of the heart lessened. Clinically, perfusion is improved and the heart protected against epinephrine-induced arrhythmias. The central action of droperidol, exerted on the reticular activating system, produces a state of mental calmness and apparent freedom from anxiety and psychic stress.

After neuroleptanalgesia patients remain tranquil but are not obtunded. The higher cortical centers are not affected. The patients can cooperate and respond to questions. When not stimulated by questions or conversation they return to the neuroleptic state of calm detachment. This characteristic is of great value in the preoperative phases.

Droperidol, given intramuscularly as a premedicant and intravenously for induction and maintenance, provides the homeostatic stabilization that is notably lacking in other general anesthetic techniques. Add to drop-

eridol, nitrous oxide—that workhorse of anesthesia—and hypnosis is produced.

The analgesic component of general anesthesia is provided by the second drug of NLA, fentanyl citrate.⁹ This drug might be considered a distant relative of meperidine, but it differs markedly in potency and duration of action. Fentanyl is the most powerful narcotic analgesic known today, being one thousand times more potent than meperidine and at least one hundred times more potent than morphine. The biologic half-life of fentanyl is only 30 minutes. Clinically, this means that half the analgesic effect is dissipated every half hour and will require constant replacement.

The remaining component of general anesthesia, muscle relaxation, is not a property of NLA and must therefore be supplied by a suitable curarizing or depolarizing neuromuscular blocking agent. All currently used relaxants are compatible with NLA.

Thus two relatively new but thoroughly investigated drugs, droperidol and fentanyl, in conjunction with nitrous oxide—oxygen and a muscle relaxant, provide a complete anesthetic technique of great promise and safety. Together they provide the four components of general anesthesia:

Hypnosis—nitrous oxide

Analgesia—fentanyl

Muscle relaxation—any muscle relaxant

Homeostatic stabilization—droperidol.

Uses and Advantages

The striking absence of myocardial depression clinically has led us to use NLA for all heart operations on adolescents and adults. The very potent antiemetic effect of droperidol exhibited from the preoperative to the postoperative phase has been of great value in dealing with unprepared patients requiring emergency surgery. In dental, ophthalmic, and plastic surgery, where nausea and vomiting could pose a threat to sight or life, or during hours of delicate surgical procedures, NLA is unparalleled.

Before the advent of NLA, tracheal intubation of a fully awake patient was a traumatic experience for both patient and physician. Now it is possible and relatively simple to introduce a tracheal tube without the use

of muscle relaxants and with the patient's active cooperation.

With the aid of NLA, it is also possible to perform an endoscopic examination of the pharynx, larynx, tracheobronchial tree, and esophagus without the use of relaxants and with a degree of patient cooperation otherwise possible only with idealized topical techniques. The maintenance of respiratory-tree dynamics by the patient's voluntary control of breathing has been of inestimable value to the endoscopist, whether otorhinolaryngologist, thoracic surgeon, or anesthesiologist.

It may be desirable or even essential to leave an endotracheal tube in place following thoracic or other major surgical procedures. This, too, is facilitated by the calm analgesic state marking the postoperative phase of NLA. While we have not yet succeeded in persuading patients to insert the tube themselves, it is usual for them to remove their own tubes at the appropriate time. In many cases they move from the operating table to the stretcher or recovery room table by themselves.

Technique

When first heard, such reports of the advantages of NLA should and do give rise to doubts. Our experience with the technique for more than a year has amply confirmed the claims advanced by its originators. While verbal reports are useful and necessary, only personal observation and conduct of the technique can convey its full impact.

Droperidol alone serves as the premedicant. The dose ranges from 5 to 10 mg given intramuscularly one-half hour before induction. This is an important step in the technique and should not be omitted.

While droperidol is administered intramuscularly for premedication, it is given intravenously in combination with fentanyl throughout the period of anesthesia. The concept of the NLA unit is useful. It is simply a 500-ml bottle of lactated Ringer's solution containing 25 mg of droperidol and 0.5 mg of Fentanyl. When fluids must be restricted, as in heart operations, a 250-ml bottle of Ringer's solution with a micro-drip set may be substituted. The important detail to re-

member is that droperidol and fentanyl must be administered in an infusion, not as the concentrate from the ampul.

The ratio of droperidol to fentanyl is important. It has been determined clinically that one part fentanyl to 50 parts droperidol is the optimal proportion.

The first 100 ml of the NLA unit is given fairly rapidly (100-120 drops/minute). The patient, already calm and relaxed from the premedication, now experiences increasing lassitude and soon closes his eyes. Fentanyl, the narcotic analgesic, is a respiratory depressant but will not of itself produce loss of consciousness. It is remarkably free from the histamine-release phenomenon so often seen with natural and most synthetic narcotics.

To combat the respiratory depression, we unashamedly resort to a specific stimulant: We tell the patient to breathe! We say: "Take a deep breath. Breathe in! Breathe out!"

In poor-risk patients (ASA classes 3 and 4), oxygen is given by mask from the onset of the NLA infusion. Pure oxygen at a high flow (8 liters or more) is continued until intubation. In classes 1 and 2 patients, the administration of nitrous oxide—oxygen, in a ratio of 2:1 and at high flows (8 and 4 liters), is started after the first 50 to 100 ml of the unit are given. The anesthetist must not forget to tell all NLA patients to breathe in, breathe out, because they simply forget to breathe. There is no paralysis involved; voluntary control is present from the cortical level.

With nitrous oxide—oxygen inhalation, hypnosis ensues rapidly. After the first 100 ml the drip rate is halved and respiration is assisted and controlled. Between the 150 and 200 ml mark a relaxant is given and intubation carried out. If intubation without a relaxant has been elected, the patient will open his mouth on command and a topical spray can be introduced. As a guide for intubation without relaxants, 250 to 300 ml of the first NLA unit will be required.

For abdominal surgery, full doses of a muscle relaxant will be given and controlled ventilation maintained. In thoracic surgery and cardiopulmonary by-pass, smaller doses

are required. The patient's response to surgical stimuli is judged by the pulse rate, blood pressure, and condition of the skin.

Intubation is followed by the period of stabilization. This implies that sufficient analgesia and homeostatic protection is achieved for the given patient in response to the given operation. Stabilization is manifested by a constant pulse rate. A rise in blood pressure or pulse rate indicates inadequate analgesia. Occasionally bradycardia (a rate of 60 or less) will be noted. This increased vagal activity is corrected by 0.2 or 0.4 mg of atropine given intravenously.

As the alpha-receptor blockade becomes established, peripheral and visceral vasodilation occurs. If a relative hypovolemia develops, it will be unmasked. Volume expansion by the use of lactated Ringer's solution is an appropriate response, provided the preoperative hemoglobin and hematocrit values are sufficiently high. If blood has been lost, is being lost, or is expected to be lost, the deficit must be made good and continuing loss replaced by pre-warmed whole blood. Under full neuroleptic receptor blockade, blood pressure becomes a linear function of the circulating blood volume. We find the following principles helpful:

1. To have blood pressure, there must be blood.
2. When the blood volume is adequate, the blood pressure is only relatively important.

Adequate perfusion is the goal of circulation. With nonconstricted vascular beds and an undepressed myocardium, together with enough blood to fill the vascular system volume, pressures of only two-thirds the "regular" pressure of the nonanesthetized patient are adequate. NLA is the technique of choice in shock, if volume replacement can be rapidly carried out.

When stabilization has been achieved, the drip rate is decreased again. A 2:1 proportion of nitrous oxide—oxygen is maintained. It is possible to restore communication with the patient simply by switching to oxygen alone. This is very valuable during neurosurgical procedures when subjective evalua-

tion is required. Some early European neuroleptic techniques made no specific attempts to produce hypnosis, but with a few exceptions it should be achieved with nitrous oxide.

In many cases the first NLA unit will suffice; in long operations, however, a second unit may be required. While fentanyl has a biologic half-life requiring continuous infusion, droperidol remains active for not less than four to six hours. Clinically, there seems to be no advantage in giving more than 50 mg of droperidol including the premedication, in a 12-hour period. Thus, the second unit of NLA will consist of a 500- or 250-ml bottle of lactated Ringer's solution containing the full amount of fentanyl—0.5 mg—but only half the original dose of droperidol—12.5 mg.

The infusion should be stopped 30 minutes before the end of the operation. The muscle relaxant must be antagonized by atropine-neostigmine if a curarizer, or allowed to wear off if a depolarizing agent was used. As the last sutures are being placed, the flow of nitrous oxide is turned off, the rebreathing bag dumped, and a high flow of oxygen turned on. One minute later we start calling the patient by name, again telling him to take a deep breath and open his eyes. In less than five minutes more than 80% of the patients will do just that. They then remove the endotracheal tube on command and move with minimal assistance to the waiting bed or stretcher. If desired, the tube is left in place.

The postoperative phase is characterized by a calm, analgesic patient who may appear to be dozing, but will respond easily to questions and simple commands. Analgesia is usually prolonged for four to six hours, and occasionally longer. There appears to be an altered evaluation of pain which generally dispenses with the need of narcotics.

It is extremely important to alert the recovery room and floor nurses as to what to expect of the neuroleptic patient, and to make a stringent rule that no narcotic or sedative drug whatsoever be given in the first four-hour period. Narcotic analgesics are not required and their administration could lead to serious complications. The re-

maining fentanyl and droperidol exert a strong additive or possibly potentiating effect on other drugs. If after the four-hour period the patient complains of pain, a non-narcotic analgesic should be tried first. After that, greatly reduced doses of narcotics, such as one-fourth the conventional dose, can be administered intravenously, but only after the four-hour waiting period. Violation of this rule has led to serious problems.

The intrinsic safety of neuroleptanalgesia lies in the low systemic toxicity of the drugs used—nitrous oxide, a muscle relaxant, droperidol, and fentanyl; but it also depends upon pharmacology purity. Never mix NLA with other drugs.

Conclusion

This what we know and understand about neuroleptanalgesia. The more one uses it, the more one comes to appreciate its value and scope. It is a technique par excellence for the physician-anesthetist, challenging the best of his knowledge and skill. We believe it should become this decade's contribution to anesthesia.

Droperidol (Inapsine), fentanyl (Sublimaze) and the 50:1 mixture of droperidol and fentanyl (Innovar) were supplied for clinical investigation by McNeil Laboratories, Inc., Fort Washington, Pa., 190304.

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North Carolina's Comprehensive Mental Health Plan

EUGENE A. HARGROVE, M.D.* AND JACQUELINE M. RANSEDELL**

RALEIGH

On March 30, at a news conference in Raleigh, North Carolina's Comprehensive Mental Health Plan was formally presented to Governor Dan Moore by executive personnel of the State Department of Mental Health, members of the Board of Health, and other officials. On this occasion Governor Moore announced approval by the United States Surgeon-General of a construction plan for building comprehensive community mental health centers across the state. The construction plan is an integral part of the total comprehensive plan and the only segment requiring federal approval.

North Carolina's Comprehensive Mental Health Plan is the product of an exhaustive, two-year study by a research team from the University of North Carolina, headed by Dr. Harvey Smith of Chapel Hill. The recommendations contained in the six-volume, 2,000-page report represent the important first step in bringing a network of community-based mental health facilities, services, and programs within the reach of citizens from Manteo to Murphy.

The plan explores in depth existing mental health resources, needs, and problems; recommends priorities for constructing regional comprehensive community mental health centers across the state; and furnishes guidelines for planning and developing

From the State Department of Mental Health.

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Request for reprints to the North Carolina State Department of Mental Health, Raleigh (Dr. Hargrove).

mental health programs in the years ahead.

Actual groundwork for the study was laid in 1962 with the passage of the Appropriations Act for the Department of Health, Education, and Welfare. This legislation provided \$4.2 million for grants-in-aid to support comprehensive mental health planning in all 50 states.

Former Governor Terry Sanford designated the North Carolina Mental Health Council, an organization composed of representatives from public and private state-level agencies concerned with mental health activities, as the agency responsible for executing long-range mental health planning for North Carolina. The Medical Society of North Carolina is one of the member agencies of this Council.

The State Hospitals Board of Control, later to become the State Board of Mental Health, was designated as the agency to administer federal funds for the planning study.

In June of 1963, Dr. Harvey Smith, University of North Carolina sociologist, accepted the position of executive director of the planning effort. During the remainder of the summer he recruited staff, and in September the task of preparing the Comprehensive Mental Health Plan was begun.

Construction Plan

About the time Dr. Smith and his staff assumed their responsibilities, Congress passed the Community Mental Health Centers Act. This legislation authorized the appropriation of \$150 million over a three-year period to finance up to two-thirds of the cost of constructing comprehensive community mental health centers pending approval of each state's comprehensive plan. Now that North Carolina's plan has been approved, the state is eligible for these federal matching funds.

The federal government will provide 63% of construction funds for the centers; the state, 22% of the cost up to \$50,000; and local funds, the remaining 15%.

At the same time the Community Mental Health Centers Act became law, each state was requested by the federal government to submit a construction plan for comprehensive community mental health centers. The North Carolina Department of Mental Health and

the Medical Care Commission were assigned joint responsibility for programming and construction of the new centers. Both agencies worked closely with the planning staff, which was assigned the chief responsibility for preparing the construction plan.

North Carolina's construction plan divides the state into 27 mental health service areas (composed of one to seven counties), each having a population base of between 75,000 and 200,000 persons. Priorities for constructing comprehensive mental health centers in each of these regions were established after surveys denoted those areas which are in greatest need of the mental health services.

Each of the comprehensive mental health centers will be required to provide five essential services: inpatient services, outpatient services, partial hospitalization, 24-hour-a-day emergency services, and consultation and education. These centers will be staffed by teams of professional workers including psychiatrists, psychologists, and social workers. Since the plan was completed, legislation to provide funds for staffing these centers has been passed by Congress. Federal matching funds for staffing are now available on a declining basis for a total of 51 months.

North Carolina's construction plan is unique in its flexibility, leaving considerable initiative to local communities. Counties in low priority areas, as well as those in regions receiving high priority, can apply for construction funds if they have sufficient local matching funds on hand.

Development of the Comprehensive Plan

The first year of developing the Comprehensive Mental Health Plan for North Carolina was devoted to collecting data from local and state resources. Communities across the state were called upon to assist the researchers in their task of gathering information on the local level. Community leaders in each of the state's one hundred counties were asked to form county mental health planning councils. These councils surveyed the resources, needs, goals, and organization of their areas in terms of forming local groups to analyze resources and needs and plan for implementation of goals.

Members of the planning staff worked closely with these local groups as they carried out their regional studies and evaluations. Written reports of their findings, together with their suggestions, were submitted to the planning staff. Additional data on needs and goals were obtained through similar surveys conducted by the Mental Health Council and special studies conducted by members of the planning staff. Data secured from all these sources furnished the information necessary to establish the 27 mental health service areas and priorities on the basis of need.

The second year of the planning effort was devoted to assessing, analyzing, and interpreting the data and preparing the Comprehensive Plan for submission to federal authorities. The study was completed in July, 1965, and published the following month.

The uniqueness of North Carolina's Comprehensive Mental Health Plan lies in its *total approach* to the needs and problems of its citizenry. Unlike other state plans, which limit their study to mental health problems and needs, North Carolina's plan goes a step further, examining in detail the multi-faceted social and economic problems in evidence in many areas of the state.

The study reveals emotional problems and mental illness arising in areas where incomes are low, health facilities limited, and suicides, alcoholism, unemployment, illegitimate births, and other social problems are prevalent. Suggested mental health programs for these areas outlined in the state plan include the services of prenatal and pre-school clinics, schools, and public and private agencies, among others.

Graphically documented in the study is the fact that North Carolina falls far short of providing much-needed community mental health services for its citizenry. Some parts of the state, particularly the far western and extreme eastern counties, are completely without mental health services, and many counties have no plans to develop any. Other counties provide only the barest minimum of mental health services. Of the 32 full-time and part-time community mental health clinics in the state, none yet offers a complete

range of comprehensive mental health services, although many are moving in that direction.

Implementation

Now that North Carolina's Comprehensive Mental Health Plan has been approved, the State Department of Mental Health and the Medical Care Commission are currently processing applications for construction funds from communities across the state. Applications approved by the two state agencies will be forwarded to Washington for consideration by the National Institute of Mental Health. If this agency approves, construction funds will then be allocated to the mental health authority in each community.

At present, applications from Alamance and Cumberland counties have been approved by federal and state authorities. Construction plans from Wake, Jackson, Guilford, and Wilson counties have been submitted but not yet approved on both the state and federal level. A number of other counties are currently preparing their applications. Included in this group are Mecklenburg, New Hanover, Cleveland, Buncombe, Durham, Nash-Edgecombe, Gaston, Halifax, Lee, Moore, and Rutherford counties.

In the future, as comprehensive mental health centers spring up in communities across the state, more and more persons with emotional illnesses can be treated near home and family in familiar surroundings. The wide range of services that these centers will provide will make it possible to treat many types of mental and emotional disorders—to treat the aged and the alcoholic, the neurotic and the depressed. The same type of comprehensive medical and rehabilitative services that are now provided in many communities for physically ill persons will be provided for the emotionally ill by these mental health centers.

Conclusion

Hopefully, the increased availability of community-based mental health services to all the people of North Carolina will mean that many mental and emotional disorders can be caught in their early stages, when complete recovery is most likely.

Necessity of Emergency Medical Information

From the Physician's Viewpoint

JOHN W. MORRIS, M.D.

MOREHEAD CITY

Any physician who has been called upon to treat accident victims is acutely aware of the value of having the patient's medical history readily available before instituting treatment. If the patient himself is unable to give this information and no member of his immediate family is present, the desirability of having this information on the person injured is even greater.

The urgent need to know what medical conditions or diseases a patient may have had prompted an effort to establish some uniform identification card or symbol. As is frequently the case, a person may be brought into the emergency room unconscious or so severely dazed that he is unable to supply the information needed. A medical information card in his wallet can be of great assistance to the attending physician as he tries to help the patient.

Various types of symbols in the form of a metal plate on a chain which can be worn around the neck or on the wrist or ankle are available from a number of sources. Such a symbol immediately informs the physician that this patient does carry significant medical information which should be considered in the plan of treatment. The emergency room personnel then knows to search the injured person's belongings until the medical identification card is located.

Conditions Warranting Identification

A number of conditions warrant the use of medical identification. Some think that the card and symbol should be carried only by persons with health problems which might be aggravated by treatment received in an emergency. I hold to this view for strictly practical reasons. In light of the vast numbers of people who travel in automobiles today, always subject to accidental injury, it

would be an overwhelming task to win universal acceptance of the practice. Thus it would seem wise to concentrate on the most significant factors affecting treatment.

Among the conditions likely to be encountered and about which information is urgently needed are arterial diseases requiring the use of anticoagulants, and conditions being treated with cortisone and its derivatives. Other conditions which should be listed, not necessarily in the order of importance, are epilepsy, diabetes, hypoglycemia, hemophilia, postlaryngectomy (neck-breathers), drug sensitivities and allergies, and conditions which cause recurring periods of unconsciousness, including cardiovascular and cerebrovascular disease.

Medical identification cards should also be carried by children, the senile, the deaf and mute, those with language barriers, and any others who could be considered noncommunicative.

Information To Be Included

What medical information should an individual carry? Two types were suggested at a conference on emergency medical identification sponsored by the American Medical Association in April, 1961: (1) basic information, to be included on all emergency medical identification devices; and (2) optional pertinent information determined by the individual and his physician.

The basic information should include the patient's name, identification of the disease or health condition requiring special consideration, the status of tetanus immunization, and the blood type, including the Rh factor. It would also include important medication which the patient should continue to receive, and any severe allergies, particularly sensitivity to drugs such as penicillin, the sulfonamides, or horse serum, which he might be given as part of his emergency treatment.

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\$200.00	Up to \$40,000.00	\$5,000.00	\$234.50	\$176.00
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The Driver's License Project

Knowing the impracticality of getting the general public to carry medical identification cards, the North Carolina Committee on Trauma, organized by the North Carolina Chapter of the American College of Surgeons, conceived the idea of including some of this important information on the North Carolina driver's licenses. While this proposal was being discussed, it was learned that North Carolina driver's licenses were being expanded into a folded, four-page card. Among the proponents of this project was Dr. James F. Newsome of the University of North Carolina, and he and other members of the Committee on Trauma met with the State Medical Society Committee Advisory to the State Department of Motor Vehicles. As the result of the efforts of these two committees, the Driver License Division of the Department of Motor Vehicles agreed to provide space for this information on the new driver license form. Because many people use their driver's licenses for identification, it was decided to put this personal information about the driver's health on the third page of the form, where it would not be seen when the license was used for other purposes of identification.

Following the adoption of the new license format, a reproduction of page three, with a brief discussion of the innovation, was published in the NORTH CAROLINA MEDICAL JOURNAL for February, 1965, and subsequently reprinted in the *Journal on Trauma*. The article attracted considerable interest, and inquiries were received from a number of states and the Canadian Province of Ontario. Recently, the North Carolina Chapter of the American College of Surgeons endorsed a resolution requesting the College and the National Safety Council to support this or a similar program in all 50 states. A similar resolution proposed by the Montgomery County Society was approved by the Medical

Society of the State of North Carolina at its annual meeting in Asheville, in May, 1966.

Advantages and Limitations

The inclusion of important medical information on the driver's license eliminates the necessity of carrying an additional card or wearing an identification bracelet or necklace. In every state it is a legal requirement that a driver carry an operator's license on his person while operating a motor vehicle. Also, this document is inspected by the investigating officer shortly after an accident. As Dr. Newsome has pointed out, whether the form used in North Carolina is ideal may be open to question, but many variations in the individual states could still be utilized to carry out the purpose.

A significant limitation to the usefulness of the driver license as the only source of medical information is that many people, including children and many old people, are not licensed to drive. It is often more important for the attending physician to have medical information pertaining to these people than that of persons of driver-licensing age. To correct this situation, it has been suggested that similar space be made available on Medicare identification cards. Whether this is feasible or not, I do not know.

Another drawback to the entire program has been forcefully brought home to those of us who are especially interested in getting everyone to carry medical information on his person while riding in motor vehicles. We have found that only an extremely small percentage of holders of the new licenses have seen fit to put this information in the space provided. It was recommended, and is so stated on the license itself, that the driver should get his family physician to help him complete this information.

The fact that so few people have utilized this opportunity to protect themselves in case of an accident points up a vital factor which must be considered when any effort of this type is being encouraged. The average citizen today will not do very much to safeguard his own life on the highway.

Having been vitally interested in the problem of traffic safety for the last five or six years, and having studied the driving habits

of the people on our highways, I am more than ever convinced that the only way we are going to make people drive with regard for others is to saturate our highways with patrolmen and electronic devices in a rigid enforcement program. The only really safe drivers I see observing the speed limit and other traffic regulations are those who have seen a patrol car and still have it in view. As soon as the patrolmen leaves the immediate area, the drivers return to their old habits.

This is true not only in North Carolina but all over the country, as well as I have been able to determine. On a recent trip to New England I observed the same situation in virtually every state I touched, though it was less marked in New York because of the large number of patrolmen in evidence.

A colleague of mine, traveling by taxi from New York City to one of its suburbs, passed the scene of a very bad accident involving several cars. After the cab driver had gingerly bypassed the debris and emergency vehicles standing by, he turned to the physician-passenger and said, "Isn't it funny? Whenever drivers pass an accident like this they drive very slowly and carefully—for about three blocks!"

I am frankly cynical about the success of our efforts to get people to carry, on their persons, pertinent medical information which might save their lives in an emergency. Consider the monumental effort that went

into the seat-belt program, and then read the ever-increasing reports of people who are killed in traffic accidents because their seat belts weren't fastened. Even after the manufacturers installed belts on the front and back seats of cars, people everywhere daily neglect or refuse to buckle their seat belts, despite repeated statements that 75% of all fatal accidents occur within 25 miles of home. If people won't observe this simple precaution to save their lives, how can we expect them to go to all the trouble of procuring and filling out medical identification cards?

That is the question that must be answered by this committee. It is a challenge that should be met, and met with determination, dedication, and the realization that any success will be hard won.

Frankly, I do not know of any effective method of dealing with the problem, but I believe that great benefit could come from a saturation treatment of the physicians of this state. Once they are convinced of the value of the cards, perhaps they would keep a supply in their waiting rooms and instruct their office help to encourage the patients to fill out the blanks. But I do not believe the public will do so voluntarily.

I respectfully submit that the need for the program exists, and that some lives will be saved by it even if only a relatively small proportion of our population cooperate in carrying it out.

Fermented liquors, though exclaimed against by many writers, continue to be the common drink of almost every person who can afford them; we shall rather endeavor to assist people in the choice of those liquors, than pretend to condemn what custom has so firmly established. It is not the moderate use of sound fermented liquors which hurts mankind. It is excess, and using such as are ill-prepared or vitiated.—William Buchan: *Domestic Medicine, or a Treatise on the Prevention and Cure of Diseases by Regimen and Simple Medicine*, etc. Philadelphia, Richard Folwell, 1799, p. 63.

The Coming of Modern Medicine to Haywood County

VIRGIL MARVIN MESSER
WINSTON-SALEM

Haywood County is located in the Blue Ridge Mountains of Western North Carolina, bordering on Tennessee on the northwest. It has a population of 39,711 (1960), which, like that of most of the southeastern United States, is preponderantly white, Anglo-Saxon, and Protestant. The economy is both agricultural and industrial, the products of the former being primarily apples, tomatoes, and tobacco, and those of the latter, furniture, paper, shoes and foam rubber items. Among its more prominent claims to fame (or notoriety, depending on the point of view) are that the last skirmish of the Civil War occurred within its borders (about one month after Lee's surrender), and that it contributed to the state its present governor. The medical problems of the county are not unlike those of the rest of North Carolina, although some staff members at certain centers of learning and healing in the "more advanced" Piedmont like to refer nonspecifically to bizarre cases as having "come out of the mountains."

As stated in the title, this paper concerns the coming of modern medicine to Haywood County, emphasizing the beginnings. I have not attempted to describe the present state of affairs, as this is beyond the scope of this paper. By "modern medicine" I mean the art and science of organized medicine as it is known today.

Early Practitioners

Before there were any formally educated physicians in Haywood County, the people relied on "grannies" and "yarb" (herb) doctors. The former were qualified by experienced, while the latter pursued a more experimental approach; both used methods passed down from generation to generation by word of mouth. There were also the midwives, whose function has now been usurped by the obstetrician. The midwives had little knowledge of obstetrics as compared to what is known today, but they did remarkably well in view of the conditions. They functioned as a sort of gen-

eral "woman doctor." Some had a fair knowledge of simple home remedies, rubs, and poultices, and many of their medications gave relief and perhaps cured.¹

The first licensed practitioner in the county on record was Dr. Archibald Osborne, licensed between 1840 and 1850. Another of the earliest physicians in the county was Dr. Samuel Love, who turned politician and was elected to the North Carolina General Assembly in 1856. He served as a surgeon during the Civil War and resumed private practice after the war, but then returned to politics.¹ In the Waynesville area, just after the Civil War, were also Drs. H. M. Rogers, G. D. S. Allen, and R. V. Welch. Drs. R. L. Allen, H. L. McFayden, R. C. Ellis, and J. H. Way began practice in the 1880s, followed by Drs. J. F. Abel, B. H. Greenwood, Thomas Stringfield, J. R. McCracken, and Samuel Stringfield in the 1890s and around the turn of the century.

Among the physicians who practiced in the Canton area during the second half of the last century and the early part of the present one (that is, up to 1906) were Drs. M. C. Millender, J. H. Mease, J. E. Moore, Joseph Russell, Herbert Mease, Francis Davis, Robert Pegram, T. F. Reynolds, and A. P. Willis. During the same period, in the Clyde, Crabtree, and Fines Creek area, there were Drs. C. R. Roberts, R. L. Walker, F. M. Davis, S. B. Medford, J. W. Reynolds, and W. A. Graham. One of the first and well remembered doctors in the Bethel area was Dr. J. E. Wilson. These men were among Haywood County's early physicians.

The circumstances under which these men practiced were vastly different from those known today, though I hope the spirit in which they practiced remains the same. Traveling on horseback, Dr. Allen ministered to almost the whole of Haywood County in the seventies and eighties of the last century.²

In cases of serious illness or accident the doctor went to the patient, and was often away from home for several days at a

¹Bowman Gray School of Medicine, Winston-Salem, N. C.

time. Dr. Wilson once stayed 24 days with a patient who was seriously injured from a riding accident. Procedures regarded as major surgery today might well have taken place on the kitchen table of some remote cabin, with poor lighting and lay assistance. Dr. Way wrote of one such operation on a young man who developed dysphasia and painful convulsions one week after incurring a seemingly minor scalp wound in a fight:

Coming quickly to the conclusion that I had some intracranial lesion inducing convulsions and disturbing articulations to deal with, preparations were made for trephining, which was done by the light of a small kerosene lamp and a lantern. The sole professional assistance was given by Reece Crawford, a farmer, 'reveneur' and bear hunter of local repute, and another layman of similar qualifications. . . . The index finger was passed through the opening of the skull and moving backward beneath the cut discovered something hard and unyielding. Pressing the easily yielding brain tissue aside, I saw a knife blade embedded in the brain, extending downward, inward, and forward. With a Hey's saw each end of the stab wound and my trephine bore were connected. I then saw that the blade was broken off smoothly at the inner table. With a small pair of dressing forceps the blade was broken off smoothly at the inner table. With a small pair of dressing forceps the blade was carefully withdrawn. It was the big blade of the ordinary farmer's pocket knife and measured exactly 1 5/8 inches in length. . . . Reaction from the anesthesia was prompt, the convulsions ceased, the articulation became normal almost immediately and a very satisfactory recovery ensued. Two months later after the operation he he was doing full time in a logging camp and expressed himself as feeling perfectly well.³

These physicians often rendered services with little expectation or hope of remuneration, and often when pay came it was in the form of farm products such as meat, vegetables, and eggs. Their offices were usually in their homes, and many also had a "medicine room" from which they dispensed drugs to their patients.

These men recognized the value of new methods of treatment and the latest discoveries in medicine, as well as the value of self-education. Dr. Abel, who received his medical training at Baltimore University Medical School and Hospital and Johns Hopkins Medical School (where he came in contact with the well-known Dr. William H. Welch), was especially noted for this characteristic:

Dr. Abel was forever seeking to learn—that he might do more for his patients. In 1909 he went back to Johns Hopkins for clinical work in gynecology under Dr. Howard A. Kelly and pediatrics under Dr. Von Pirquet; later back in Baltimore again he had microscopy under Dr. Charles Simon, pediatrics under Dr. Mason Knox, and attended surgical clinics at the Hopkins Hospital. . . . In 1919 Dr. Abel spent weeks in the Augustana Hospital, Chicago, and in the Clinical Laboratory of Surgical Technique. In 1920, he spent eight weeks as a surgical interne in Cook County Hospital. In 1921, he attended for twelve weeks clinics at the American Hospital and lectured at the Illinois Post-graduate Medical School. In 1923, he spent 12 weeks working as an interne in the American Hospital. Almost annually he attended (12 weeks in all) summer clinics at the Johns Hopkins Hospital, and in 1929 he spent six weeks in Dr. George Crile's Thyroid Clinic at the Lakeside Hospital, Cleveland.²

In this era the patient was always central and foremost in the successful handling of any medical problem, by necessity as well as by choice, and we must admit that this was, and is, a desirable approach.

. . . Dr. Abel knew the constitution of his patient. He took no formal course in psychiatry, but he practiced it daily. He knew his patients and they believed in and trusted him—and in large numbers they got well. But there was a further factor in Dr. Abel's very successful practice of medicine—his deep understanding of the hearts of people in great trouble. A family was in great distress and a call went to him over the telephone. . . . "Dr. Abel, please come at once. We do not need the physician, but we sorely need the man."²

It is to men such as these that we owe our gratitude for the prestige enjoyed by the medical profession today.

The County Medical Society

The Haywood County Medical Society was organized in the office of the late Dr. J. Howell May on August 2, 1889, with five members enrolled. Dr. Charles R. Roberts of Clyde was elected president, and Dr. R. C. Ellis of Waynesville, secretary. Later other members were added until in a short time every licensed physician in the county became a member. In 1905, under the inspiration of Dr. May, the North Carolina Medical Society was reorganized and the Haywood County Medical Society became the first in the state to become "a component county medical society of the Medical Society of North Carolina."⁴

The Haywood County Hospital

The first hospital in Haywood County

was a small privately owned hospital which was set up in 1917 in what had been the Bonnicastle Hotel in Waynesville. The inadequacy of this institution to provide medical service to the area is implied in one description of it: "The building was ill-adapted to its new purpose, its equipment was scanty to the point of poverty, and only by courtesy could it be called a hospital."² In 1925, in the same building, the Haywood County Hospital was organized.

In June of 1925 a group of interested and leading county citizens held a meeting to discuss the possibility of building a larger, more modern hospital. A campaign was organized for this purpose, and a bond election was held in July, 1925, but the issue was defeated. In an election the following year, however, the people approved a bond issue of \$100,000 and at the same time authorized a tax levy to provide a maintenance fund and pay interest on the bonds and retire them. This was one of the first counties to take advantage of the state law providing this method of financial hospital construction.

A hospital board was named and a site purchased. Shortly after an architect was employed and plans were drawn, it became evident that the building and equipment would cost more than the allocated amount. The hospital board appealed to Dr. W. S. Rankin of the Duke Endowment for advice and financial aid. The trustees of the Duke Endowment, who heretofore had only aided a small group of hospitals in maintenance costs, made their first contribution to the construction of a hospital anywhere by donating \$10,000 to the Haywood County project.

The four-story, 75-bed structure was completed in 1927, and the formal opening was held on the last day of that year. In 1933, because of crowded facilities, a nurses' home was built adjacent to the hospital so that the nurses' quarters in the hospital could be converted into rooms for patients. The Duke Endowment paid half of the \$12,000 cost of this building. Owing to the well remembered economic crisis which had swept over the country at this time, much of the labor was drawn from relief rolls, and brick from

the dismantled county jail was used in the construction. Since that time many improvements and additions to the hospital have been made, including two major ones in 1952 and 1958, making it a modern 154-bed facility. There are 31 physicians on the staff, including a full-time radiologist and a full-time pathologist. In addition, there are departments of inhalation therapy and physical therapy and, adjacent to the hospital, a school for licensed practical nurses.

The Public Health Program

A brief look at conditions generally prevalent before most of our modern drugs and methods of treatment were developed, and before the importance of preventive medicine was realized, will help us appreciate the service rendered by public health programs to rural and small-town areas such as Haywood County. Immunization by vaccines was unknown, and diseases such as diphtheria were known to have been fatal to all the children in some families. Epidemics of measles, typhoid fever, scarlet fever, and pneumonia were common, being largely due to lack of sanitation and preventive measures. Tuberculous patients were not isolated, so that more than one member of many families succumbed to this disease; the prevalence of carriers of infectious agents such as the tubercle bacillus needs no comment.

Since medical science at this time could offer little relief and much less in the way of prevention or cure, the people had only their religious faith to turn to. "Prayers for protection and relief were heard on all sides. But families resignedly continued to bury their dead, and ministers tried to comfort with the words, "The Lord giveth and the Lord taketh away.'"¹

The first extensive public health concepts to which the county was exposed came with the hookworm campaigns initiated in the Southern United States and tropical America by the Rockefeller Sanitary Commission and the Rockefeller Foundation during the first quarter of the present century. These campaigns were primarily oriented toward educating the people in sanitation, personal hygiene, and disease prevention. Lectures, exhibits, and public health literature, as well

as demonstration of results in terms of improved health, were the methods used.

The role of the local government in maintaining the health of the community was strongly emphasized. This project marked the beginning of active public health work in this area and was the first step toward the organization of health departments and other agencies concerned with public health. The campaign reached Haywood County in the fall of 1913 and was described by one of the field workers who worked in North Carolina, British Guiana, and Trinidad:

Our success in Haywood County was due to the excellent cooperation we received from the county officials. Mr. Boyd, chairman of the board, was much interested and Mr. R. E. Sentelle, the superintendent of schools, although an old gentleman, went with us during our educational work and urged the teachers to cooperate. Another factor we had not enjoyed before was the sympathetic assistance of the doctors. Dr. J. Howell Way, president of the State Board of Health, lived in Waynesville and was of course interested, and Dr. J. R. McCracken, the county physician, went with us to lectures and demonstrations and assisted at the dispensary points. Also, mention must be made of the interest and assistance of Drs. Thomas and S. L. Stringfield of Sunburst, and of Drs. J. E. Wilson, R. L. Allen and J. F. Abel, all of Waynesville.

The Haywood campaign was conducted along conventional lines. The survey showed few sanitary privies, but more of the open type than had been found in the lowlands. The county abounds in springs and streams and the privies in most instances were placed over these. As we traveled over the county it looked as if every sizeable stream was polluted in this manner. Especially was this true at small villages and lumber camps. Drinking water in many country places was obtained from springs, but few of which were protected from surface water. Because of this the percentage of infection with roundworms was high. Also, several cases of tapeworm were encountered.

The county's population was 15,436 by the 1910 census and of these, 3,119 were examined, of whom only 200 were infected with hookworms. As to permanent results the Board of Education took steps to have sanitary privies and a safe water supply provided at each school.⁵

The Haywood County Health Department was organized in 1931, with offices in a small room in the rear of the Haywood County Courthouse in Waynesville; it boasted one sanitarian and a budget of \$3,186. In 1934 Haywood joined with Jackson and Swain counties to form a District Health Department, with headquarters in Waynes-

ville. The staff consisted of one health officer, one supervising public nurse, four other public health nurses, two sanitary inspectors, and one clerk-stenographer. In 1935 this district was enlarged to include Macon and Graham counties; the total budget at this time was \$27,405.68. In 1949 Haywood County withdrew from the district department to organize a single-county health unit, and in 1955 the offices were moved from the basement of the county courthouse into a new and modern health center building just outside Waynesville.

Conclusion

Modern medicine came to Haywood County because, as in all other parts of the world, there was a need for it, and that need was exemplified by the patient affected by disease. Medicine was established and flourished because there were dedicated men who were proud to be called "physician," yet were humble enough to realize the limitations of their knowledge, and thus gave their best efforts to applying this knowledge.

Thus there existed from the beginning what Dr. Hugh Matthews, a family physician now practicing in Haywood County, refers to as "the basic unit or 'cell' of medicine, the patient-physician relationship, with the patient as the physician's justification for being."⁶ There were also citizens of the county who saw the need for a hospital and a public health program, and who played an integral role in bringing modern medicine to Haywood County.

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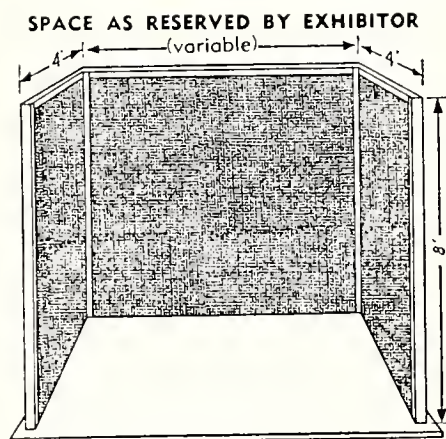
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OCTOBER, 1966

WHAT HAPPENED IN SOUTHERN PINES

(The Fall Executive Council Meeting)

While convening urologists played golf in the bright sunshine, the members of the Executive Council and those in attendance upon them labored for nine hours straight (with 45 minutes out for lunch) on Sunday, October 2. This was the regular fall meeting of the Council, and much needed to be done; an agenda of 75 items was covered. Attendance at the committee meetings of the four pre-

ceding days was extremely good and the quality of the work high.

Following the "ladies first" principle, Mrs. Leon Robertson started the meeting by giving a good account of our active Auxiliary's plans. With 2568 ladies working on problems of health education, student aid, entertainment and hospitality, we have a mighty resource, and Mrs. Robertson and her associates have their work well organized. Auxiliary activities are now aided by having a secretary in the Raleigh headquarters office of the State Society.

The Finance Committee gave an encouraging report, showing that we are operating on a sound fiscal basis with a balanced (but barely) budget. No major budgetary changes have been proposed for the next fiscal year.

The legislative committee reported that Congress has done little with health legislation during recent months, although many of the bills which were introduced and not acted upon will no doubt come up again in the next (90th) session. Preparations are being made for the 1967 term of our state legislature, with the possibility of action by chiropractors to expand their legal position.

The prospects for annual meeting places are all centered on Pinehurst. The 1967 meeting will be held there, activities beginning on Saturday, May 30 (Executive Council) and the meeting proper ending on Wednesday, May 24. The Carolina will be the headquarters hotel. Major session topics will include marriage counselling, venereal disease, a symposium on renal disease, mental health activities, and the status of the regional medical program.

On the topic of the regional medical program there is significant progress to report. As most of our members are aware, North Carolina is among the first states to receive grant funds to plan activities under the so-called "heart, stroke, cancer" law, largely because of well-organized action by the State Society and the three medical schools. A director has been employed and has set up shop at Duke. The Executive Council ratified the Articles of Agreement for our regional program and tended to our involvement in it.

It was suggested that the election of Editorial Board members and members of the

Board of Medical Examiners be removed from the General Sessions to the House of Delegates.

The continuing effort to provide a headquarters facility for the Society was this time centered on the decision as to whether to build in downtown Raleigh adjacent to the state offices with which so much business is done, or to use a site on the edge of town. Additional information was needed, and the subject will be taken up again at the January meeting of the Executive Council.

The Professional Insurance Committee has been active, and the members will shortly get a new group life insurance plan which will be the least expensive insurance available through any source. Details will come to each member in a letter from the Ralph Golden agency. Should 40% of the membership take the insurance, no medical restrictions will be imposed. Our experience with professional liability insurance will be published in the *Journal* as a report from this committee. It can be summarized as outstandingly good, with North Carolina enjoying the lowest premium rates in the nation. The insurance carriers attribute this, in part at least, to the activities of the Professional Insurance Committee of the Society. The experience thus far this year has not been so good, and the carriers are currently at their break-even point; hence all our members must be vigilant if low premiums are to continue in force.

The completion of the history of the State Society, a project which has occupied much of Dr. Roscoe McMillan's considerable energies for many years, is now in sight. Money has been provided for the editing of the many manuscripts which have been assembled, and this work will begin in about a year. Publication will be dealt with after the editorial work is done. Many of the people who have worked on the various subdivisions of the history have spent considerable sums out of their own resources in gathering material, and the final product should be a monumental work and a credit to the Society.

The Committee on Constitution and By-Laws observed that our own constitution is only 25 years younger than that of the United States, and a great deal more complex than

that of the AMA (which is younger). An effort will be made to prepare a complete index to the Constitution and By-Laws, as a prelude to eventual extensive revision of that document.

The Insurance Industry Committee is not currently plagued with problem cases for review, and has been working on the problem of proper compensation for hospital visits. The handling of Medicare claims is not presenting any unusual difficulties; about 3500 cases per week are being processed by the insurance carrier (but 1300 were handled on the Monday before the meeting).

On several occasions it was emphasized that the members should understand that Title 19 of the Medicare law—the provision of health services to indigent people—has not been implemented in North Carolina. A number of plans have been approved; what New York and California have done has caused Congress to have some second thoughts about that title. Several official groups of the Society are studying the problems of this provision of the law, and will make recommendations to appropriate bodies when the time is ripe.

The Maternal Health Committee took notice of the need for additional facilities in the state for the care of unwed mothers. Present services are inadequate and cannot accept these unfortunate girls until they are in their seventh month of pregnancy, when the need for privacy which stimulated the founding of these homes is no longer a consideration. Some charitable organizations are considering entering this field.

The Negotiations Committee, perennially plagued by the matter of fee schedules, was directed by the Council to continue its efforts and was assured of its support.

As the meeting drew to its close the President, Dr. Frank Jones, told of his reluctant, but essential decision to activate four committees. One, the Venereal Disease Committee, has actually been reactivated; one hopes that the next time it is mothballed will be the last. Committees on the regional medical program, a Society function review committees, and a long-range planning committee are the others.

The above account is only a brief summary of those agenda items which seem of widest interest. Our readers can readily imagine that many tired brains and oppressed glutei went away from Southern Pines that evening.

* * *

THE DOCTORS

By the time this editorial appears there should have been quite a hue and cry in the public press about Martin Gross's book, "The Doctors," a 570-page tome published by Random House, and a prepublication selection of a number of book clubs. It is flattering, in a sick sort of way, that when Gross says "doctors" he means physicians, perhaps to assure himself of an eager audience as he "exposes" skeletons he sees in medicine's closet.

Perhaps one could summarize Gross's complaints against the medical profession by saying that he is sad and dismayed to find such a large number of human beings in its ranks. When a group of roughly 240,000 physicians sets out to deal with the health needs of 200,000,000 people, there are bound to be mistakes made. Mr. Gross has marshalled some important information to indicate things that are wrong with U. S. medicine, and interestingly enough, most of his information comes from sources within the medical profession. This point is made because the profession, by and large, is critical of itself and anxious to do what is right. Mr. Gross's insistence that medicine is lax in regulating its practitioners does not take into account the difficulty of making judgments on many matters he would like judged.

In his attack on the medical profession in the field of competence, Mr. Gross cites what he considers a very low figure for candidates failing medical licensure examinations (2.3% for graduates of U. S. schools in 1965), and says that it is difficult to fail out of medical schools once the first two years are passed. Would Mr. Gross have the medical schools admit incompetent students so they could fail a percentage which would please him? The medical schools do everything in their power to admit only students who are physically, emotionally, and educationally equipped to study medicine, and each failure on the part

of the student is considered a failure on the part of the school. It is hoped that failures in screening candidates for admission would be detected as early as possible in their medical school career, to avoid inflicting incompetent students on the patients with whom they work. His characterization of medical licensing exams as a "joke" would come as news to most physicians, who dread them. Most candidates from U. S. schools pass because they respect the exams, study for them, and have gotten good training. When Gross holds up the high failure rate on bar examinations as evidence that the medical profession is lax in its examinations, he fails to make the alternate interpretation that legal education is less rigorous and law students less carefully chosen as compared to medical students.

Medical education is described in the book as inadequate in many ways, in no small measure because faculties are labeled as interested only in research. This is a considerable oversimplification. Medical schools attempt to blend teaching, patient care, and research in such a way as to get the best of all three. At times, because of many reasons too complex for study here, one or another aspect has gotten too much attention. But the profession has called its own to account for transgressions, and medical school curriculums are presently under intensive study, with many new approaches being tried. Such things take time and great sums of money, but they will eventually help the medical schools in their task of training the people who will be practicing in the year 2000, when the research front of today will only be a part of medicine's past history.

One of Mr. Gross's key charges is that physicians *cause* a great deal of illness. There is a morsel of truth in this. While physicians can hardly compete with the abuse the general public inflicts upon itself in wars, in automobiles, and by general neglect, there are potentially dangerous medications used each year. There is a certain amount of risk involved in taking anything into the body, including chicken salad at a church picnic. To say that this danger is treated with contempt by the profession is something else again. Many interested medical groups

are working on the problem of getting information on dangerous methods of treatment to physicians as quickly and effectively as possible; the task is enormously complex and will not be accomplished by simplistic admonitions.

What Mr. Gross chooses to call "assembly-line" medicine comes in for scorn when he says it is "mainly for the doctor's convenience and greater income." In fact, without a constant effort to have people other than physicians do some tasks formerly done by physicians, we would have a doctor shortage of staggering proportions and the cost of medical care would be greatly increased. Most of the people who complain that the physician does not spend enough time listening to them would be unwilling and unable to pay for that time.

"Neglect" on the part of physicians gets considerable attention. Failure to make bacterial cultures of infected throats is cited as an example of medical negligence, on the grounds that failure to recognize a strep throat may lead to rheumatic fever, even though a strep throat is easily cured with penicillin. Mr. Gross fails to mention that most patients would be unwilling to pay for such a throat culture, and are much happier about paying for the penicillin which is given to them without such confirmation of the diagnosis. Another example of what he considers neglect is the fact that many physicians do not use the sigmoidoscope in the course of routine physical examinations. Some careful students of these matters have pointed out that inclusion of such a procedure in a routine physical examination would cut down the number of patients the doctor could examine, while turning up very few cases of disease. All "screening" examinations have to be weighed in a balance against feasibility, in terms of medical value, cost, and people available to do the tests.

To the extent that Mr. Gross's book shakes the confidence of the public in their physicians, and especially in the good intentions of the profession, it may be harmful. Fortunately, despite the impression one gains from

the book that physicians are rapidly becoming venal, incompetent and unloved, most people would say that such a description applies to someone else's doctor rather than to their own. To the extent that the book brings home to the public the enormous cost of improving health services, cost to be borne individually and as taxpayers, it is useful. One gains the impression, however, that sensation may be more the object than information.

* * *

THEODORE SIDNEY RAIFORD, M.D.

On August 28, 1966, while en route to Asheville from Chicago, where in recent years he had gone so often in the interest of our profession, Ted Raiford was suddenly and fatally stricken. Without complaint and with what those close to him knew to be extraordinary physical sacrifice, this fine surgeon set for himself a high standard of dedication. He devoted himself unsparingly in time and energy to the responsibilities placed upon him by his colleagues.

Although plagued by physical adversity, Ted Raiford, in a brief span of three years, served as president of the North Carolina Surgical Association, the North Carolina Chapter of the American College of Surgeons, and the Medical Society of the State of North Carolina. He possessed a great capacity to think positively, to implement effectively, and to exercise superlative leadership.

An idea conceived by Dr. Raiford in 1962 and promoted with unrelenting zeal led to the founding of the National Association of State Medical Society Presidents, an organization to serve as a forum for the discussion of problems and objectives confronting medicine nationwide. Though endowed with unusual ability, Ted Raiford freely and unhesitatingly sought the counsel of his colleagues.

A remarkable blend of superior talent, self-effacing humility, and high resolve characterized the life of this doctor who contributed so much to his community and to his profession.

J.S.R.

The President's Page

HEALTH NEEDS TODAY

One cannot hope to make other than a limited exploration of the subject, "Health Needs Today." Much, therefore, must be left unsaid.

Definitions

First, what is health? Health is a state of being hale or sound in body, mind, or soul, especially freedom from physical disease or pain. Man's basic aim, whether he realizes it or not, has always been the preservation of a state of good health: *health*, in order that he might wage a continuous struggle in the battle with the elemental forces of existence; *health*, that he might secure adequate food in order to withstand the ever-present ravages of disease, injury, and time; *health*, in order that a healthy mind might adequately guide and support him in his contest for ascendancy over the other forms of life on this planet.

Needs? How wide the definition of this word is! One source defines it as a condition requiring supply or relief; the lack of anything requisite. From here it is easy to slide into a word that will often be parallel in the intent of expression. How easily need equates itself with want. The outermost reaches of the Milky Way might serve as the periphery of a container for the wants of man. When a man wants something, sooner or later he convinces himself and others that his want is his need.

At this moment I want to stop taking night calls. The time will come when I will need to stop taking night calls. This want will then become the demand of a physical or emotional need. Thus a want can be converted by circumstances into a more compelling factor—a need.

Logan Pearsall Smith, speaking of needs in 1902, said: "But when in modern books, reviews, and thoughtful magazines, I read about the needs of the age, its complex questions, its dismays, doubts, and spiritual agonies, I feel an impulse to go out and comfort that bewildered epoch." Smith wrote this in the dawn of this century—that period which

we look back upon as the epitome of placidity. He spoke of the needs of the age, of complex questions, dismay, and doubt. Each epoch creates its concept of these matters, dependent entirely upon the circumstances of the time.

Health as a state of being has no need except to be sustained. A state of non-health exhibits a need—a need for measures to combat the onslaught of disease and injury, measures designed to restore a state of well-being. Health may have a want; non-health has a need.

A moment ago we mentioned time. What is today? Regardless of the exact position of this moment in time, a large portion of today has slipped into yesterday. At high noon, anywhere in the world, half of today has been relegated to the past, to history, to the pale from which there is no recall. Therefore our consideration must deal with what is left of today and, hopefully, the ever-present tomorrow.

What is rural? What is urban? By certain statistical means of measurement, some states are classified as rural and some as urban. We cannot, however, in this day and time, separate rural from urban when it comes to health. Megalopolis or hamlet, ghetto or isolated farm, tropic or tundra—all have the same ultimate want: surcease from the ills of body and mind. Circumstances peculiar to one geographic or sociologic area make certain facets of the health effort different, but the broad principles are the same.

Now that we have torn our subject apart and defined our terms, I do not feel so fenced in.

Longevity

We all want to live in good health for a long time. That is an almost irrefutable statement of desire. We want to live longer than our forefathers did.

At the turn of the century the life expectancy of a newborn white child born in the United States was 48.23 years for males and

51.08 for females. By 1962 the expectancy had risen to 67.6 for males and 74.4 for females, an increase of 9.37 years and 23.32 years respectively. For nonwhites during the same period, the increase in life expectancy for the male was 8.96, and for the female an astounding 31 years.

As we look at the national statistics for 50 years onward, we do not see a similarly striking increase in life expectancy. Without adjustments for population percentages as to color, the average expectancy for males who have attained 50 years of age has increased as of the present only by 3.17 years, and for females 6.97 years.

Each "statistic" who sits and breathes will readily recognize that the breakthroughs have been the decrease in infant mortality, the advances in sanitation, the control of epidemics, and the virtual erasure of fatalities associated with the contagious diseases of childhood and youth. These areas of control and the improvements in maternal care have led to the marked increase in general longevity. Medicine and the allied sciences have led in this battle against disease and death. It is they which are responsible for the accomplishments in sanitation; which have supplied the know-how and sparked the efforts that have resulted in the weakening and near banishment of many of the scourges of mankind.

The average age of our population is increasing, and as one looks ahead he must realize the ills that become manifest after the age of 45. We must, and we will, take a growing interest in those diseases that are heralded by an advance agent of the pale rider. This herald is called aging.

If we consider that our efforts are to be limited to patching and refurbishing the middle-aged population in order to achieve that end, we will be defeated in our ultimate aim. We must not wait until the middle years to begin our attack against degenerative diseases such as arteriosclerosis; upon destructive diseases such as malignant neoplasms; and upon malfunctions of the heart. These are not diseases of middle or old age; they only become more evident then. The machinery wears out, and the wearing out

process becomes apparent in the signs and symptoms of these classes of disease. These diseases, in my opinion, have their origin in early life. There are those who say that much of the option for the degenerative diseases goes back even further. When? The moment that the spark in papa's eye is reflected in the gleam in mama's eye. I refer to familial tendencies.

Human genetics will undoubtedly play a significant role in many of the diseases that afflict us. In my opinion, our people must develop a more sophisticated level of thinking before the findings along this avenue can be properly utilized. A strong investigative program should be instituted in this area, which could become one of the great fields of preventive medicine.

Accidents and Environmental Hazards

Accidental injuries and deaths are increasing, in particular those due to traffic accidents. We need an ongoing program directed toward the reduction of these occurrences and increasing emphasis on the availability of quality care after the accident has happened.

A developing concept in medical thinking concerns problems related to our environment. This environment may be that created by nature or—more important to this discussion—that created by man's rape of nature. What are these problems? First air pollution: smog, carbon contamination, radiation effect, chemical sprays on food stuffs. Next, water pollution—by chemicals, destruction of watersheds, bacterial invasion of water sources, silt, and deoxygenation of available water by exogens.

The third problem has to do with urban rather than rural health, but we are so involved today as a result of our mobility that we cannot separate the two. The migration from country to city makes the problem of urban health a concern of the total community. The situations that give rise to disease in the crowded city affect the rural community as well. Thus, because of the interchange of people, the health needs of a tenement district become the problem of rural people as well. The industrial environment,

working conditions, mechanization are all involved in the health needs of today.

Immunization

A complete program of immunization against preventable communicable diseases must be put into action in order to weaken the potential of these diseases

Manpower and Facilities

It is said that in our immediate tomorrow the health care field will be the greatest employer of people in the country. Where are trained people coming from? We must say, first of all, that to measure health care by quantity alone is absurd; we must have quality as well. Without it, we will have gained nothing.

The need for personnel is chiefly in the paramedical fields. New health care programs have created a drain on the reservoir of trained people, presently in short supply. As we increase the quantity of health care on paper, we will unquestionably dilute the quality of care now available. Unless we increase the supply of trained people to work with the physician and under his direction, we cannot hope to bring both quality and quantity of care to our people. Whom do I mean? Nurses, laboratory and surgical technicians, sanitarians, health aides, trained medical attendants, "mechanotechs," record librarians, anesthesiologists, research assistants, physiotherapists,

other therapists, and so on and on. These people, adequately trained and adequately paid, are mandatory if we hope to provide health care on a quality basis.

The need to make the techniques and the equipment of the medical center available to the community hospital is apparent. We must find ways of bringing semi-urban or rural areas those modalities of diagnosis and treatment that are developing so fast in this day and time. We need to encourage a program of ongoing medical education for all levels of medical personnel. We must make it possible for the physician to return to medical school to recharge his batteries from time to time. Ancillary personnel must have the same opportunity. The brains in the medical center are no better than those in your local community; they only have more sophisticated tools to work with; and these tools can be brought to the outlying community on either a lend-lease or a step-and-fetch it basis.

One last word: Bricks, stones, and concrete do not cure illness or care for the injured: people do. Adequately trained human beings, in reasonable numbers, backed by programs of basic research. Research into what? Even into the primary cellular physiology—why life and why death? And then the application of research to the preservation and restoration of health.

FRANK W. JONES, M.D.

By jumbling together a number of different ingredients, in order to make a poignant sauce or rich soup, the composition proves almost a poison. All high seasoning, pickles, etc. are only incentives to luxury, and hurt the stomach. It were well, if cookery as an art were prohibited. Plain roasting or boiling is all that the stomach requires. These alone are sufficient for people in health, and the sick have still less need of a cook.—William Buchan: Domestic Medicine, or a Treatise on the Prevention and Cure of Diseases by Regimen and Simple Medicine, etc. Philadelphia, Richard Folwell, 1799, p. 63.

Bulletin Board

COMING MEETINGS

Society of Nuclear Medicine, Southeastern Chapter—Jack Tar Hotel, Durham, November 3-5.

Southern Thoracic Association, 13th Annual Meeting—Grove Park Inn, Asheville, November 3-5.

North Carolina Pediatric Society—Mid Pines Club and Golfotel, Southern Pines, November 4-5.

Symposium on "Emergency Medical Care"—Amphitheater, Bowman Gray School of Medicine, November 10-11 (Conducted for alumni of the medical school.)

Society of Pelvic Surgeons, McGuire Lecture Series—Medical College of Virginia, Richmond, November 17-19.

North Carolina District, American College of Physicians—North Carolina Society of Internal Medicine, Joint Meeting—Charlotte Memorial Hospital, Charlotte, December 9-10.

1967 National Rural Health Conference—Charlotte, March 10-11, 1967.

NEW MEMBERS OF THE STATE SOCIETY

Fuller Adams Shuford, M.D., I, 3 Buena Vista Rd., Asheville

Robert Lassiter Young, Jr., M.D., Pd, 103 W. 27th St., Lumberton

Gerson Asrael, M.D., U, 1350 Kings Drive, Charlotte

William Eugene Keiter, Jr., M.D., Pd, 400 Glenwood Ave., Kinston

Donald L. Copeland, M.D., GP, 515 E. Statesville Ave., Mooresville

Eugene Douglas Maloney, M.D., P, 623 E. 2nd Ave., Gastonia

George Vernon Irons, Jr., M.D., I, 1350 Kings Drive, Charlotte

Moses Lawrence Kouri, M.D., GP, 2028 Woodland Drive, Charlotte

Allen Edward Grippo, M.D., P, 1009 College St., Kinston

Patrick Martin Reames, M.D., R, 4732 Aspen Court, Charlotte

Nathan Leslie Burkhardt, Jr., M.D., Or, 108 Doctors Bldg., Asheville

Harry Holler Summerlin, Jr., M.D., GP, Tunnel Rd., Asheville

Andrew Thompson Wiley, M.D., S, Keystone Drive, Route 3, Box 50-C

NEWS NOTES FROM THE UNIVERSITY OF NORTH CAROLINA SCHOOL OF MEDICINE

Dr. C. Arden Miller, 42, former medical school dean at the University of Kansas, has been appointed Vice Chancellor, Health Sciences of the University of North Carolina.

Dr. Miller will have administrative responsibility under Chancellor Carlyle Sitterson for the schools in the Uni-

versity's Health Center, including School of Dentistry, School of Medicine, School of Pharmacy, School of Public Health, School of Nursing, N. C. Memorial Hospital, and the Health Affairs Library.

An internationally-prominent pediatrician and medical administrator, Dr. Miller also will be a full professor.

He was dean and provost of the School of Medicine and Medical Center of the University of Kansas from 1960 to 1966, and has just returned from London where he worked in a program with handicapped children under auspices of the Department of Education and Science in England.

He is a native of Shelby, Ohio, a graduate of Oberlin College, and received his M.D. degree at Yale University Medical School in 1948. He has taught and practiced pediatrics in New Haven, in Kansas City, and as director of the Children's Rehabilitation Unit of the University of Kansas Medical Center. Dr. Miller was named a Markle Scholar in Medical Science in 1955.

* * *

The National Science Foundation has awarded a grant of \$70,500 to Dr. Mary Ellen Jones, associate professor of biochemistry at the UNC School of Medicine, for a two-year study of enzymes. Her primary interest will be in enzymes with an essential role in the chemical processes which form proteins and nucleic acids.

* * *

Deaths on the gridiron from head and neck injuries and from heat stroke are the major safety problems pinpointed in the 34th annual Survey of Football Fatalities.

The report, covering a period from 1931 through 1965, was issued by Dr. Carl S. Blyth, director of UNC's Laboratory of Applied Physiology and chairman of the Committee on Injuries and Fatalities of the American Football Coaches Association.

Most of the deaths blamed directly on football for the last five years have been caused by head and neck injuries. In 1965 alone, 24 of the 25 fatalities related directly to football resulted from these types of injuries.

* * *

Dr. T. Franklin Williams, a specialist in internal and preventive medicine at the UNC School of Medicine, has been granted a year's leave of absence for special study at Vanderbilt University School of Medicine in Nashville, Tenn.

He will work as a Special Fellow with Dr. C. R. Park, chairman of the Department of Physiology. Their research will deal with the biochemistry and physiology of hormones.

* * *

A new Division of Education and Research in Community Medical Care has been established at the UNC School of Medicine to plan and coordinate the increasing activities in community medicine more effectively.

Dr. W. Reece Berryhill, professor of medicine and dean emeritus, has been appointed director of the division, and Dr. Carl B. Lyle, assistant professor of medicine, will serve as assistant director.

Dr. Berryhill said the new division will have three major objectives. It will establish affiliations with a

few of the larger community hospitals in working toward the development of regional medical educational centers.

It will establish one or more demonstration centers in rural areas in as effort to improve the quality and availability of medical care and to provide training opportunities for medical students.

And it will provide opportunities for members of the UNC medical faculty interested in medical care research to study disease patterns and the medical needs of North Carolina communities.

* * *

A new salary schedule for registered nurses at N. C. Memorial Hospital provides increases in starting salaries ranging from \$700 to \$1,500 a year, depending upon education and experience.

Eugene B. Crawford, Jr., hospital director, said that salary adjustments have been made for all levels of registered nurses.

As an example, the nurse graduating from a hospital school of nursing—the "diploma nurse"—with no experience has a new starting salary of \$457 per month, or \$948 a year more than previously. She could expect a salary adjustment after six months on the job and another increase after one year's experience.

He said also that appropriate salary increases have been proposed for all other nursing personnel employed by the hospital.

* * *

A unique experiment dealing with the effects of radia-

tion on life expectancy and blood-forming organs will be conducted by a radiological physicist at the UNC School of Public Health.

The U. S. Public Health Service has awarded a \$46,392 grant to Dr. Donald G. Willhoit for a three-year study of "The Comparative Effects of Two Radiation Exposure Regimens."

A special laboratory being developed near the UNC campus will house a breeding colony of experimental mice and the exposure chambers for the project. Gamma rays, a penetrating type of radiation used in the treatment of cancer, will be delivered to the mice in two different manners. One group of mice will be exposed continuously, 24 hours a day. A second group will receive the same amount of radiation each day in a period of only 30 minutes.

Dr. Willhoit explained that the two types of exposure simulate to some degree the exposure patterns of concern in the radiation exposure of humans.

* * *

Funds totaling \$6,855 have been approved by the policy board of the University of North Carolina Population Studies Center for research on sex hormones.

The funds will provide partial support for one year for work being conducted at the UNC School of Medicine by Dr. Frank S. French.

The research, centered in the Division of Pediatric Endocrinology, has been in progress for two years. It deals with the mechanism of action of androgenic hormones and seeks a better understanding of hormone effects on tissues involved in reproduction.

* * *

Miss Ruby Christine Cunningham, a medical laboratory technician assigned to clinical microbiology at N. C. Memorial Hospital, has been awarded the Army Commendation Medal for outstanding service with the Woservice with the Women's Army Corps (WAC).

The Army citation was for service at Fort Sill, Okla., while Miss Cunningham was serving as supervisor in the clinical bacteriology section of the Pathology Service at Reynolds Army Hospital.

* * *

The State Board of Higher Education has approved a \$1,000 grant to the University of North Carolina for a series of radio programs dealing with venereal diseases. The UNC School of Medicine will provide an additional \$400 for the series.

Dr. William P. Richardson, assistant dean for continuing education at the medical school, said the programs will be directed toward more effective recognition and treatment of syphilis and gonorrhea and the development of better cooperation in reporting and investigating these diseases.

The special series is a part of the two-way radio medical conference schedule which began October 11 and will continue through April 6. The exact dates for the programs will be announced later.

The U. S. Department of Health, Education and Welfare has awarded \$42,000 to UNC at Chapel Hill under the new Health Professions Scholarship Program.

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The funds will be allotted as follows: \$18,400 for beginning students in the School of Pharmacy, \$14,000 for beginning students in the School of Medicine and \$10,000 for beginning students in the School of Dentistry.

The program is entirely financed by the federal government.

NEWS NOTES FROM THE DUKE UNIVERSITY MEDICAL CENTER

A nationally known figure in medical administration has assumed duties as executive director of North Carolina's Regional Medical Program for combating heart disease, cancer, and stroke.

Dr. Marc J. Musser, deputy chief medical director of the Veterans Administration, Washington, D. C., took over in mid-October as operational chief of the new all-out effort against the nation's three deadliest diseases.

Dr. Musser also has held posts as assistant chief medical director for research and education in medicine, and director of research service for the VA Central Office in Washington. He has served as professor of medicine at both the University of Wisconsin Medical School and the Baylor University College of Medicine.

The program Dr. Musser will direct is being supported initially by a two-year, \$574,532 grant under a fund set up by the federal government specifically to combat heart disease, cancer, stroke and related diseases. It is a joint undertaking of the Bowman Gray, Duke University, and UNC medical centers and the Medical Society of the State of North Carolina, representing about 4,000 doctors, with support from a number of health-related organizations. By pooling the resources of these groups, medical leaders hope to insure that the latest advances in diagnosis and treatment of the major disease killers will be continually available to the people of the state.

The first step will be a move to strengthen relationships between the medical centers and community hospitals by an affiliation between the universities and three community medical facilities. Bowman Gray will link with Memorial Mission Hospital in Asheville, UNC with Moses Cone Hospital in Greensboro, and Duke with Cabarrus Memorial Hospital in Concord. These affiliations are designed to keep the hospital staffs abreast of the latest information on control of heart disease, cancer and stroke.

Four other steps have been outlined as ultimate goals of the program. They are:

—Establishment of effective communications between the various groups concerned with health care.

—Establishment of a continuing survey of the effectiveness of all medical programs.

—Establishment of a program of post-graduate education at a variety of professional levels.

As director of the Regional Medical Program, Dr. Musser will be responsible to its board of directors.

The board is composed of the deans and one other representative from each of the three medical schools, the president and three other representatives of the

State Medical Society, the state health director, the chairman of the North Carolina Medical Care Commission, the president of the North Carolina Hospital Association, and the dean and one other representative of the UNC School of Public Health.

Dr. E. Harvey Estes, Jr., of Durham, board chairman, is head of the Department of Community Health Sciences at the Duke Medical Center. His offices are in Durham.

* * *

Atop the Gothic columns of Duke Medical Center, a new radio station has begun beaming emergency medical consultation and advice to doctors working in remote areas throughout the world.

Project MED-AID (Medical Assistance for Isolated Doctors) has officially gone into operation, according to an announcement by Dr. E. Croft Long, project director and assistant dean of the Duke University School of Medicine. Dr. Long said that the 1,000-watt station will be on the air from 9 a.m. to 5 p.m. (EST) daily.

The primary purpose of the project is to bring expert and instantaneous consultation about the latest developments in diagnosis, treatment, and prevention of disease to doctors working in field stations, mission outposts, and jungle hospitals.

Dr. Long said that thus far 14 medical outposts and isolated hospitals in Africa and Latin America that are equipped with shortwave amateur radio equipment have indicated they will take part in the program immediately. Six more outposts are expecting to get the needed equipment soon and to join the network, and another 23 have expressed a desire to take part if they can get the necessary equipment.

Project MED-AID is informally affiliated with AMDOC in Santa Barbara, Calif., an organization that helps doctors in bush stations and field hospitals by sending American doctors as temporary replacements; and with the Direct Relief Foundation in Santa Barbara, a charitable organization that distributes several million dollars worth of free drugs to missions all over the world.

The Duke radio station will handle messages from other health-related organizations on an emergency basis, in circumstances where legally permissible, Dr. Long said.

Project MED-AID was made possible by a grant from the Mary Reynolds Babcock Foundation in Winston-Salem.

* * *

A Duke University professor has accepted an invitation by New York's Mayor John Lindsay to join a newly formed Management Science Advisory Council to help the city solve some of its administrative problems.

He is Dr. Max A. Woodbury, chief of the division of bio-mathematics at Duke University Medical Center and a nationally known mathematician.

Serving with Dr. Woodbury on the voluntary Management Science Advisory Council are outstanding computer experts, teachers of business administration, and scientists from all over the country.

Dr. Woodbury came to Duke in January from New York University. There, he had been professor of ex-



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perimental neurology and director of the school's communication science section since 1962.

He is an advisor to the National Institutes of Health, the World Health Organization, and a former vice president of the Institute of Management Sciences as well as fellow of the American Association for the Advancement of Science, the American Statistical Association and the Institute of Mathematical Statistics and a member of many other professional organizations.

* * *

Dr. J. Leonard Golfer, professor of orthopedic surgery at Duke University Medical Center, delivered the founder's address at the third annual Sumner L. Koch postgraduate program on surgery of the hand at Cook County School of Medicine in September.

Dr. Koch, in whose honor the program is conducted, founded and directed for many years the hand surgical service at Cook County Hospital.

* * *

Dr. Frans F. Jobsis, associate professor of physiology at Duke University Medical Center, was one of two Americans invited to deliver lectures at an international medical conference in Budapest, Hungary, Sept. 19-24.

Dr. Jobsis delivered an address and presided over a conference on the mechanical activity of striated or voluntary muscle. Malfunction or wasting away of striated muscle is the basic mechanism by which muscular dystrophy strikes down its victims.

The Duke researcher's work and his European presentation are being sponsored by grants from the Muscular Dystrophy Association of America and the National Institutes of Health.

* * *

Two Duke scientists, Dr. Madison S. Spach, associate professor of pediatrics, and Roger Barr, a graduate student in electrical engineering, presented a paper at a conference held in Bratislava, Czechoslovakia, in September. They told how the combined efforts of medicine and engineering are providing better diagnosis of heart diseases.

NEWS NOTES FROM THE BOWMAN GRAY SCHOOL OF MEDICINE OF WAKE FOREST COLLEGE

Work is under way to develop the Bowman Gray School of Medicine and North Carolina Baptist Hospital as a major center for cancer research and training. The medical school has:

—Established a broad new program of special training for physicians in the diagnosis and treatment of malignant disease.

—Initiated a long-term planning project to evaluate the medical center's present cancer program and to determine future requirements in the areas of training, research and patient care.

These projects, through which the school's cancer-related activities will be expanded and coordinated on an interdepartmental basis, are supported by two federal grants, totaling more than \$588,000, awarded recently by the National Cancer Institute.

The program is separate from but will be closely coordinated with the Regional Medical Program on Heart Disease, Cancer and Stroke.

Dr. Charles L. Spurr, professor of medicine, has been named director of the program which will offer training at four different levels for physicians who have completed their basic clinical training. The types of traineeships range from visitorships of one-to-several days to fellowships of one-to-two years. Dr. Jesse H. Meredith, associate professor of surgery, will serve as assistant director.

Objectives of the long-term planning project, directed by Dr. Isadore Meschan, professor and chairman of the department of radiology, are to determine the strengths and weaknesses of the present cancer program and the improvements necessary for the institution to qualify as a major center for cancer research and training. Assistant directors of this project are Dr. Donald J. Pizzarello, assistant professor of radiation biology, and Dr. Clair E. Cox, assistant professor of urology.

* * *

A new radiological textbook, written by Dr. Isadore Meschan, professor and chairman of the Department of Radiology, has been released by the publisher, W. B. Saunders Co.

Published in two volumes, the work, "Roentgen Signs in Clinical Practice," contains 1,831 pages and more than 2,500 illustrations. Volume one deals with the basic principles and radiology of the skeletal system, including the skull and spine. Volume two concerns radiology of the chest, genitourinary system and gastrointestinal tract. The volumes will be sold separately with the first volume priced at \$18 and the second volume at \$20.

The book, which represents 10 years of concentrated effort on the part of Dr. Meschan and his wife, Dr. Rachel Meschan, research associate in radiology, is intended to serve not only as a textbook for medical students and advanced students of radiology but also as a comprehensive reference work for practicing radiologists.

Dr. Meschan is the author of four other radiological textbooks and the editor of still another.

* * *

Ford Foundation has awarded a \$370,000 grant to the Bowman Gray School of Medicine to support a five-year study aimed toward making family-planning services more attractive to low-income families. The program, which will be conducted in Forsyth County, will develop and test procedures for application throughout the United States and possibly overseas.

Dr. Clark E. Vincent, professor of sociology and director of the Behavioral Sciences Center, will direct the project which is focused upon poverty-level, public-welfare women of child-bearing ages who are not practicing effectual birth control and who, for various reasons, have not utilized the services of the Forsyth County Family Planning Clinic. An estimated 1,500 Forsyth County women make up this "hard-to-reach" group.

Through interview techniques, members of the project staff will seek to determine why these women do not participate in the clinic program, why they do not practice effectual birth control, what changes in clinic practices would make the program more attractive and

what new services, such as baby sitting and transportation, would make their participation easier.

Responses to the initial interviews will serve as a basis for certain experimental changes in the clinic's family-planning program. The clinic was established in 1964 as a cooperative effort of the medical school and the county's health and welfare departments.

* * *

Two peditricians received recent appointments to the faculty of the Bowman Gray School of Medicine. They are Dr. William T. McLean, associate professor of pediatrics, and Dr. Doris Y. Sanders, instructor in pediatrics.

Dr. McLean, a pediatric neurologist, has served for the past five years as assistant professor of pediatrics at Johns Hopkins University School of Medicine. A graduate of Wake Forest College and the Bowman Gray School of Medicine, he interned at N. C. Baptist Hospital and took residency training in pediatrics and neurology at John Gaston Hospital, Memphis, Tenn.; Duke University Medical Center; Children's Medical Center, Boston, Mass.; and Johns Hopkins Hospital. He was an associate in pediatrics and neurology at Jefferson Medical College from 1957 to 1961.

Dr. Sanders, who has special interests in virology and infectious diseases, spent the past year at Ohio State University School of Medicine where she was a fellow in virology and instructor in pediatrics.

A graduate of Austin Peay State College, she received the M.D. degree from Vanderbilt University School of Medicine where she took internship training. She completed pediatric residency training at N. C. Baptist hospital. Dr. Sanders is married to Dr. Weston M. Kelsey, professor and chairman of the Department of Pediatrics.

Dr. Clark E. Vincent, professor of sociology and director of the Behavioral Sciences Center, has been elected vice president of the American Association of Marriage Counselors. He will be installed in October at the association's 24th annual meeting.

* * *

Dr. Howard H. Bradshaw, professor and chairman of the Department of Surgery, was honored at the annual "Howard Holt Bradshaw Day" of the Tennessee Academy of General Practice Aug. 18 in Johnson City, Tenn. He spoke on "Pharmacodynamics of Pulmonary Emphysema."

* * *

Dr. John R. Kennedy, assistant professor of anatomy, presented a paper on "Chloral Hydrate Immobilization of Paramecium Caudatum" at the annual meeting of the American Institute of Biological Science Aug. 14-21 at the University of Maryland.

* * *

Dr. William H. McKinney, assistant professor of neurology, participated in a meeting of the American Institute of Ultrasonics and Medicine Aug. 27 in San Francisco, Calif. He presented a paper on "Basic Problems of Ultrasound and Basic Investigation of the Brain."

* * *

Dr. Carlos E. Rapela, professor of physiology, participated in the seventh Congress of the Latin American

Physiological Society Aug. 7-12 in Mar Del Plata, Argentina. He presented a paper on "Cerebral Circulation during Hemorrhagic Hypotension and Shock" and chaired a session on "Myocardium."

While in Argentina he spoke on "Peripheral Vascular Factors in Shock" at a symposium on "Shock" and presented a paper on "Catecholamines and Cardiovascular Function" at a symposium on "Catecholamines." Both symposia were in Buenos Aires.

1967 NATIONAL RURAL HEALTH CONFERENCE

North Carolina will be host to the 1967 National Rural Health Conference to be held in Charlotte, March 10-11, 1967. The 20th Annual Conference, sponsored by the American Medical Association, will be held at the Queen Charlotte Hotel, according to a joint announcement by Frank W. Jones, M.D., President of the Medical Society of the State of North Carolina, and Bond L. Bible, Ph.D., Secretary of the Council on Rural Health of the AMA.

Theme of the Conference will be "Rural-Urban Health Relationships," and is expected to attract participants from throughout the country representing rural and urban community groups interested in improvement of the health of all people.

Dr. Bible stated that one of the main objectives of the national conference is to understand more fully the interdependence of rural and urban areas for the improvement of the health of the people and to develop methods to plan for and utilize more efficiently health manpower resources. He added that by 1970 it is anticipated that the health field will be employing more people than any other industry.

Dr. Jones commented that he considered the national conference to be held in North Carolina as high recognition of our physician leadership in the state and feels certain that that the opportunity will make for better community health practices.

NORTH CAROLINA DISTRICT AMERICAN COLLEGE OF SURGEONS

The North Carolina District of the American College of Surgeons will hold its annual regional meeting, in conjunction with the North Carolina Society of Internal Medicine, in Charlotte, December 9-10.

Out-of-town guests will stay at the Red Carpet Inn, and clinical session will be held in the auditorium of Charlotte Memorial Hospital.

Additional information may be obtained by writing the chairman of the committee on local arrangements, Dr. Thomas S. Perrin, 309 South Laurel Avenue, Charlotte, N. C., 28207.

NORTH CAROLINA HEART ASSOCIATION

The North Carolina Heart Association has announced plans to expand and intensify its campaign against rheumatic fever and rheumatic heart disease in North Carolina.

In a series of meetings to be held throughout the state, the Heart Association is seeking to enlist the services of physicians and pharmacists in all one hundred North Carolina counties in the distribution of low-cost penicillin to patients on whom the cost of the medicine would work a financial hardship.

Estimates of the number of rheumatic fever victims in North Carolina range from 15,000 to 45,000. No exact figure is available because the disease is not required to be reported under state health law.

Heart Association volunteers in all North Carolina counties are now being oriented to recruit as many doctors and pharmacists in the program as possible. As operated, the program provides that a cooperating doctor selects patients to receive the low-cost medication and provides a special prescription which the patient may present to a pharmacist who has agreed to distribute the penicillin provided by the Heart Association.

Because victims of rheumatic fever must take daily dosages of the medicine for long periods of time, the cost of the medicine often works financial hardship and frequently results in the victim's not receiving proper protection against the development of heart damage.

GILL MEMORIAL EYE, EAR AND THROAT HOSPITAL

Gill Memorial Eye, Ear and Throat Hospital has announced that its fortieth annual Spring Congress will be held in Roanoke, Virginia, April 3-7, 1967.

Guest speakers will be Drs. Sidney N. Busis, Pittsburgh, Pa.; Webb Chamberlain, Cleveland, Ohio; Jerrie Cherrie, Baltimore, Md.; Michael E. DeBakey, Houston, Texas; Raymond L. Hilsinger, Cincinnati; Wendell L. Hughes, Hempstead, N. Y.; R. Townley Paton, Southampton, N. Y.; Gus A. Peters, Rochester, Minn.; Frank N. Ritter, Ann Arbor, Mich.; A. D. Ruedemann, Detroit, Mich.; Joseph A. C. Wadsworth, Durham, N. C.; Paul Ward, Nashville, Tenn.; and Robert C. Welsh, Miami, Fla.

NATIONAL SOCIETY FOR CRIPPLED CHILDREN AND ADULTS

Two students in North Carolina are among ten in the nation who have been awarded scholarships to assist them in the completion of studies in physical and occupational therapy, the National Society of Crippled Children and Adults announced recently.

They are Carol Hess Probst, University of North Carolina; and John Caramihalis, Duke University.

This scholarship program, now in its twelfth year, is made possible by the contributions of Kappa Delta Phi National Women's Fraternity. Grants are awarded to outstanding students of physical or occupational therapy who are in their senior year or in the clinical training period of a degree course.

For information about the scholarship program address the National Society for Crippled Children and Adults, Scholarship Coordinator, 2023 West Ogden Avenue, Chicago, Illinois 60612.

INDUSTRIAL MEDICAL ASSOCIATION

A competition for a \$250 award for the best manuscript submitted by a medical student, intern, or resident on any subject pertinent to and concerning occupational health has been announced by the Central States Society of Industrial Medicine and Surgery. The contest closes at midnight on December 31, 1966.

A second competition, open to residents in occupational medicine, is announced by the Industrial Medical Association. The award, consisting of an embossed scroll, will be presented at the Association's annual meeting to the author of authors of a paper published in the open literature on a subject germane to occupational medicine which is judged to be the most outstanding of those submitted prior to January 15, 1967.

Both contests will be judged by members of the Committee on Merit in Authorship of the Industrial Medical Association. The criteria will be largely based on clarity, validity, objectivity, originality, and style. Complete contest rules may be obtained from: Industrial Medical Association, 55 East Washington St., Chicago, Ill., 60602.

AMERICAN COLLEGE OF SURGEONS

A three-year grant of \$275,000 to the American College of Surgeons has been awarded by The John A. Hartford Foundation, Inc., of New York City for support of the Field Program in Trauma to improve care of the injured patient.

The Board of Regents has accepted the grant to carry out various projects in the education of the public on comprehensive emergency care, including adequate ambulance service and hospital emergency departments for communities. The grant period began Sept. 1, 1966, and will run through Aug. 31, 1969.

This is the third, three-game grant from the Hartford Foundation for the Field Program in Trauma. The first two grants were for \$150,000 each.

U. S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Seven additional states have joined a national effort for planning solid wastes pollution abatement on a state-wide basis, it was announced recently by Surgeon General William H. Stewart of the Public Health Service, U. S. Department of Health, Education, and Welfare.

The states were awarded Public Health Service grants covering 50% of the cost of making surveys and plans to end health-hazardous and landscape-marring solid waste disposal practices.

The awards, totaling nearly \$190,000 for the current fiscal year, bring to 21 the number of states participating in planning phases of the national solid waste program.

Among the states included in the recent announcement are North Carolina, \$14,400; Virginia, \$36,200; and Georgia, \$40,000.

* * *

Surgeon General William H. Stewart of the Public Health Service has stated that routine typhoid immuni-

zation is not recommended in the United States. His statement was based on findings on the Public Health Service Advisory Committee on Immunization Practices. Text of the recommendations was included in the Morbidity and Mortality Weekly Report for the week ending July 23. The Report is published by the Communicable Disease Center in Atlanta.

The Committee recommended selective immunization in the following situations:

1. Intimate exposure to a known typhoid carrier as would occur with continued household contact.
2. Community or institutional outbreaks of typhoid fever.
3. Foreign travel to areas where typhoid fever is endemic.

The Advisory Committee stated further, "Although typhoid vaccine has been suggested for individuals attending summer camps or those in areas where flooding has occurred, there are no data to support the continuation of these practices."

The incidence of typhoid fever in the United States has declined steadily for many years. At the present time, the Committee said, less than 500 cases are reported annually, and a continuing downward trend can be expected. Cases are sporadic and are primarily related to contact with carriers rather than to common source exposure.

The Month in Washington

The Advisory Committee on Obstetrics and Gynecology to the Food and Drug Administration reported that in a nine-month study it could find "no adequate scientific data" that birth control pills are "unsafe for human use."

But the committee said that there are "possible theoretic risks" in the use of oral contraceptives. For this reason, the committee recommended further, extensive tests to learn more about possible side-effects and to improve surveillance of the drugs.

The FDA accepted this proposal and other committee recommendations, including discontinuance of time limitations on use of oral contraceptives.

FDA Commissioner Dr. James Goddard said the agency would like to start studies on up to 50,000 women next year and eventually on as many as 500,000 women. The biggest drug studies thus far have involved only 20,000 or 30,000 women.

The FDA said it would lift shortly its recommended limits on use of the pill. The agency has required that manufacturers state

on their labels and advise physicians that the oral contraceptives should be used by individuals for no more than four years because of concern about the unknown long-term effect of the medications. FDA officials and the advisory committee agreed that there isn't any sound scientific rationale for the restriction, because of the current lack of data that would indicate that the pills are dangerous.

Other steps that FDA officials said would be taken as a result of the report include imposition of uniform labeling requirements on all types of oral contraceptives, elimination of product-by-product variations that have confused physicians and allowed companies to make different promotional claims, and restrictions of the use of the products for some medical purposes, such as prevention of abortion and treating lack of menstruation or painful menstruation, as well as conception control.

"The oral contraceptives present society with problems unique in the history of human therapeutics," the committee said. "Never will so many people have taken such potent drugs voluntarily over such a protected period for an objective other than for the control of disease. These compounds, furthermore, furnish almost completely effective contraception, for the first time available to the medically indigent, as well as the socially privileged. These factors render the usual standards for safety and surveillance inadequate. Their necessary revision must be carefully planned and tested, lest the health and social benefits derived from these contraceptives be seriously reduced. Probably no substance, even common table salt, and certainly no effective drug can be taken over a long period of time without some risk, albeit minimal. There is always a sensitive individual who may react adversely to any drug, and the oral contraceptives cannot be made free of such adverse potentials, which must be recognized and kept under continual surveillance. The potential dangers must also be carefully balanced against the health and social benefits that effective contraceptives provide for the individual woman and society.

"The oral contraceptives currently in use

are probably not those that will be employed 10 or even five years hence. Drugs with even less potentially adverse effect, utilizable in smaller dosage, will undoubtedly be developed through continuing research."

* * *

The American Medical Association opposed legislation that would make prescribing drugs by generic name mandatory under the federal program of medical care for dependents of military personnel.

The AMA expressed its opposition in a letter to a joint House-Senate committee that was considering such legislation. The letter said:

"The generic name refers to the active chemical ingredient of the drug and not to the finished product which is supplied to the patient. In order that it may be dispensed, the tradename manufacturer, by way of a specific formulation, processes the drug to its final form. For example, included in a manufacturer's preparation of a tablet form of a drug may be a number of variables such as the crystalline size, the nature of the excipients, the coloring agents and flavors, the tableting pressures, coating films, and the orientation within the tablet.

"Since the finished product, depending on who has manufactured it, may emerge in any one of several forms, it becomes apparent that a generic-named drug supplied by one manufacturer may differ to a significant degree from the same generic-named drug supplied by another manufacturer. Yet, if the physician is compelled to prescribe by generic name, he would have no control as to which drug is used by the pharmacist in filling the prescription.

"The coating, the disintegration time, the solubility, the choice of vehicle or base, these and other factors may be extremely important to the physician who chooses a drug for his patient. He must have the opportunity to specify that drug containing the variables he has found suitable to the treatment of his patient. Further, where his patient is receiving the same medication over a period of time, successive refills of the same prescription with products of different manufacturers,

could lead to variations in therapeutic response which may mislead him.

"It has been suggested that generic prescribing would result in substantial savings. This may be true in some instances, but certainly not in all. Generic prescribing would allow the pharmacist to furnish the patient with that manufactured drug he, the pharmacist, has chosen. It may or may not be less expensive. In any event, it is the pharmacist who sets the final price.

"The argument of generic prescribing versus trade name prescribing has been heard at scientific gatherings, seen in scientific publications, and debated in the committees of Congress. But as to one element of the discussion, almost all physicians agree. For a variety of sound medical reasons, the choice of whether to prescribe generically or by brand name should be that of the treating physician.

In Memoriam

John Homer Hamilton, M.D., 1888-1966

John Homer Hamilton was nearly a half century a pioneering public health leader in his chosen state of North Carolina. He was born in Ash Grove, Missouri, June 13, 1888, and died at Rex Hospital, March 20, 1966. His funeral was held in White Memorial Presbyterian Church and burial was in Montlawn on March 22. Members of the Raleigh Academy of Medicine were honorary pallbearers.

Dr. Hamilton graduated from Oklahoma Agricultural and Mechanical College in 1910, taught science in Cherryville, Kansas, 1910-1911; served as chemist, Pennsylvania State College Institute of Animal Nutrition, 1911-1912; and graduated from Harvard Medical School in 1916. He then served as associate bacteriologist, Division of Laboratories and Research, New York State Department of Health until 1918. The following year he was associate professor of preventive medicine and assistant director, State Public Health Laboratory, University of Iowa. During 1919-1920 he was associate state director, International Health Division, Rockefeller Foundation.

Dr. Hamilton's service in North Carolina began in 1920, when he became New Hanover County health director. He came to the State Board of Health in 1931, and in 1933 succeeded Dr. Clarence Shore as the second director of the Laboratory Division. To these duties he cheerfully added, in 1942, duties as editor of the Health Bulletin and, in 1951, as Assistant State Health Director. For brief periods he also filled vacancies in

the Division of Local Health and Public Health Statistics. He retired April 29, 1960.

Dr. Hamilton was a member of the North Carolina and American Public Health Associations, the North Carolina Academy of Public Health, the North Carolina Academy of Preventive Medicine, the Raleigh Academy of Medicine, the Wake County and North Carolina Medical Societies, and the Southern and American Medical Associations. He was a charter member and Fellow of the American College of Preventive Medicine, and served as president of the North Carolina Public Health Association, the North Carolina Academy of Preventive Medicine, and the North Carolina Academy of Public Health.

In 1963 the auditorium of the Laboratory Division was dedicated and a bronze plaque was installed naming it the John Homer Hamilton Auditorium. In non-medical affairs his interest was active through memberships in the North Carolina Harvard Club, the Executive Club of Raleigh, the State Literary and Historical Association, and the North Carolina Society for the Preservation of Antiquities.

Dr. Hamilton enjoyed his church, good music, and his family and friends. His co-workers in public health, teaching, and the private practice of medicine found in him an informed, helpful, and cheerful consultant. He took a personal interest in the career promotions of his staff and co-workers. He was the trusted counselor and teacher—always unselfish and objective. As Dr. Jacob Koomen, State Health Director, said of him: "His quiet strength and his high professional competence combined to make him a respected leader in his medical and public health relationships."

Dr. Hamilton is survived by his widow, the former Aline Brigman; a son, John H. Hamilton, Jr., of Cary; a daughter, Mrs. Lyn Evans of Charlotte, and a grandson, John H. Evans.

Whereas Dr. John Hamilton has for nearly a half century, with wise professional judgment and unselfish devotion, promoted the highest standards in public health and in private medical practice in North Carolina; and

Whereas our citizens and those yet unborn owe him a deep debt of gratitude for his many individual and public services throughout his long and effective life; therefore, be it

Resolved that this expression of respect and appreciation be formally enacted by the Raleigh Academy of Medicine and spread upon its official minutes; and that copies be sent to the family of our departed colleague and friend to convey, though inadequately, the heartfelt sympathy of the members of the Raleigh Academy of Medicine; and be it further

Resolved that copies be also sent to the North Carolina Medical Journal, the Journal of the American Medical Association, the Journal of the American Public Health Association, the Newsletter of the American College of Preventive Medicine, the Southern Medical Journal; and to the Secretary of the Medical Society of the State of North Carolina and the Secretary of the North Carolina Public Health Association.

Raleigh Academy of Medicine

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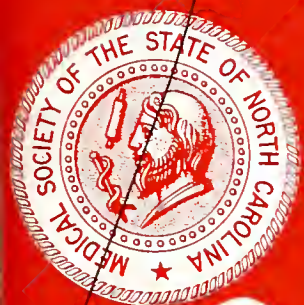
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James T. Barnes, Managing Editor



MEDICAL JOURNAL

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IN THIS ISSUE:

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JOHN S. RHODES, M.D., ASSOCIATE EDITOR

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The November Issue

Some time ago the editorial board of the NORTH CAROLINA MEDICAL JOURNAL was approached on the subject of its willingness to devote a special issue to papers honoring Dr. Robert A. Ross on his retirement as chairman of the Department of Obstetrics and Gynecology at the University of North Carolina School of Medicine. The suggestion was received with enthusiasm by everyone except Dr. Ross (who was not then a member of the board). With characteristic modesty, he felt unworthy of such a tribute. At last word he was still opposed to the publication of the present groups of papers, which composed a special program in his honor, arranged by the Robert A. Ross Obstetrical and Gynecological Society and presented at Chapel Hill on December 4, 1965. It is therefore a great pleasure to rule against our friend, editorial board member and president-elect, and carry out the mandate of the rest of the board and, we believe, of the Society—which conveys some of the deep feeling held for the man by all with whom he comes in contact.

Robert Alexander Ross

W. REECE BERRYHILL, M.D.

CHAPEL HILL

When two people have been friends for nearly 50 years and colleagues for the past 14, it is difficult, if not impossible, to maintain a reasonable degree of objectivity on an occasion like this.

The relationship between our families actually began 200 years ago, when two of our ancestors were contemporaries in the then small and largely Presbyterian school, the College of New Jersey at Princeton. Less than a decade after graduation these two men found themselves in the newly established village of Charlotte, in Mecklenburg County, North Carolina. Dr. Ross's ancestor, one Waightstill Avery, was an able young lawyer; mine, a Presbyterian minister. Both participated in the events leading up to the Mecklenburg Declaration of Independence on May 20, 1775, and were signers of this famous—though somewhat disputed—document. Mr. Avery was the Representative from Mecklenburg County in the first State Constitutional Convention held at Halifax in April, 1776, and is reported to have been the author of the paragraph in the State Constitution calling for the establishment of one or more universities for the education of the state's future leaders. In a sense, therefore, he can be called the father of the University of North Carolina. Subsequently, he became the first attorney general of the state, and was a member of the Board of Trustees of the University for a number of years.

I have cited some of the achievements of Waightstill Avery in the development of North Carolina and its University not only to indicate the long association of Dr. Ross's family with this University to which he has contributed so much, but more importantly (since in recent years the significance of genetics in the biological sciences has, in a measure, been rediscovered), to give you some insight into the character and some

understanding of the motivation and the accomplishments which have made Dr. Ross the person we all love and respect.

First of all, he is a staunch and faithful Presbyterian, devoted to his church and consistently present at its services. My wife would say that he has a "Presbyterian conscience"—whatever that may be. For Ross, I am sure it means a strong and compelling sense of duty and a devotion to what one feels is right and must be done regardless of the consequences. (I am sure Waightstill Avery had this feeling when he signed the Mecklenburg Declaration of Independence.) This attribute has always been characteristic of Dr. Ross's attitude toward his responsibilities to the University, to the state, and to his special field of interest in medicine.

Continued on page 508

Curriculum Vitae

Robert Alexander Ross is a native of Morganton, North Carolina. His undergraduate study was at the University of North Carolina, followed by medical school at Pennsylvania and residency training at Episcopal and Kensington Hospitals in Philadelphia.

He was instrumental in organizing the departments of obstetrics and gynecology at both Duke University Medical Center and the University of North Carolina School of Medicine, and he has served as professor of both institutions. Largely through his efforts, the North Carolina Obstetrical and Gynecological Society and the South Atlantic Association of Obstetricians and Gynecologists were founded.

Dr. Ross is a member of 44 scientific societies. He has served as president of the American Association of Obstetricians and Gynecologists, South Atlantic Association of Obstetricians and Gynecologists, North Carolina Obstetrical and Gynecological Society, American Gynecological Travel Club, Durham-Orange County Medical Society, Tri-State Medical Society, the North Carolina Chapter of the American College of Surgeons, and as vice-president of the American Gynecological Society.

In May, 1966, he became president-elect of the Medical Society of North Carolina.

Dr. Ross is a member of the Chorioepithelioma Registry and an Associate Examiner of the American Board of Obstetrics and Gynecology. He is the author of 96 scientific publications.

He has served in the United States Navy since 1940 and retired in 1962 with the rank of Rear Admiral.

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ROBERT ALEXANDER ROSS, M.D.

Second, those of us who have been intimately associated with Dr. Ross have been impressed again and again by the range and depth of his knowledge. He is one of the best and most widely read men I know in this university—a scholar indeed, with many interests. Among them I would mention the following:

1. As one would expect, he is remarkably well informed about, and can appraise, the developments and publications — past and present— relating to diagnosis, therapy, clinical investigation, and education in his own field of medicine.

2. His store of Biblical knowledge is phenomenal. Over and over again during the past decade, particularly at tense moments in meetings of the Medical Faculty Advisory Committee, the Hospital Board, and the general medical faculty, he has come forth with some appropriate Biblical quotation to ease the situation and, more often than not, carry his point. It was Dr. Ross who first called my attention to an oft-quoted sentence by President Johnson from the Book of Isaiah, and to the fact that the President fails to give the full import by omitting the "punch lines." When President Johnson says, "Come now, and let us reason together," he never finishes the quotation, which reads: "If ye be willing and obedient, ye shall eat the good of the land: But if ye refuse and rebel, ye shall be devoured with the sword." As the *Charlotte Observer* has remarked editorially, one does not have to be a divinity student to grasp the implication.

3. I am sure he could qualify as a professor of history. He has long been an avid student of the history of this university, of the state, of the South, especially of Burke and Mecklenburg counties, in which the Avery and Ross families have deep roots. The following excerpt from a letter to Dr. Langdon Parsons, formerly professor and chairman of the Department of Obstetrics and Gynecology at Boston University and now at Harvard Medical School, is a case in point.

We too are distressed that you can stay only a couple of weeks since we had a fairly complete itinerary for you:

1. A visit to Edenton where the natives dumped tea into the Albemarle Sound a year before the Boston Hootenanny, the chief difference being that the North Carolina Revolutionaries did not disguise themselves as Indians.

2. Wilmington where irate citizens paraded a whale boat taken from an anchored British sloop long before the battle of Lexington.

3. Charlotte for two reasons: (a) the site of the first Declaration of Independence, May 20, 1775. (b) The site of Camp Greene dear to the heart of the Parsons' household.

4. Hillsborough where Regulators were shot two years before Bunker Hill.

5. Guilford Courthouse where a female on horseback alerted the natives while Paul Revere was fashioning a silver swizzle stick. This is more noteworthy because it did not provoke a stupid poem by a dull poet who could count only to two and was obviously color blind. This poem together with the odd one proclaiming "Excelsior" is exceeded only by the blow by blow report of Sheridan's Ride.

And for contemplation, a sparkling lake which produces succulent rainbow trout rather than beer cans and other prohibited oddments found in Walden Pond.

4. In English: Not only has he a broad knowledge of English literature, but his knowledge of the exact meaning and connotation of words is extraordinary. Those of the faculty who have worked with him on reports will attest to this knowledge, and certainly his own writings show the preciseness and incisiveness of his communications by the spoken and written word.

I could not close this statement without mentioning what is perhaps the greatest of Dr. Ross's achievements — the development of the Department of Obstetrics and Gynecology in this University, his contributions in in this venture for the past 14 years, and his valuable service to the medical faculty as a department chairman over and beyond those relating to his own department.

I assume that Dr. Carter will give his own evaluation of Dr. Ross's contributions in the advancement of obstetrics and gynecology in the state, region, and nation. I shall talk only about the department here. I had long been pleasantly aware that the men Dr. Ross had attracted to his department were superior in their field. This is indicated by the opportunities some have had to accept the chairmanship of departments elsewhere, a

tribute to the quality of their teaching, patient care, and scholarly activities. Another indication is the high caliber of our own students and those from other schools who have chosen obstetrics and gynecology as their field of interest and have applied here for positions on the resident staff.

My own impression was abundantly confirmed this past year while I was on leave as a Commonwealth Fund Traveling Fellow visiting a number of medical schools from Boston to Seattle and in Scotland and England. It was reassuring to hear the high regard in which this department is held and the tributes to Dr. Ross for his accomplishments and those of his colleagues in the department he has built.

As a department chairman he has thought first of the University, second of the Medical School, and third of his department. In no sense does this mean, however, that he has not fought hard and stubbornly for his field and for those for whom he felt responsible. In this, as in all of his other undertakings, he has been unselfish, sensitive to, and understanding of, the problems of the entire Medical School, of the University, and of the state and region.

His philosophy—which I support wholeheartedly, although regrettably it is now in danger of becoming a relic of what my grandchildren call “old-timey days”—has always been that *excellence in teaching and patient care come first*, and must always be so if undergraduate students and the house staff are not to become “paupers instead of princes” in the medical center—to borrow a phrase from Dr. Carl Moyer, formerly of Washington University School of Medicine. At the same time Dr. Ross has appreciated keenly the importance of acquiring new knowledge through investigation, and has encouraged his staff in these endeavors both in clinical studies, in which he participated, and in the laboratory. It will be a tragic day for medicine in this and other schools if and when a reasonable balance between teaching, patient care, and research ceases to be maintained.

As the chief administrative officer of the

Medical School for most of Dr. Ross's years here, I shall always be grateful to him for his consideration for others, for his perceptiveness, and for his keen sensitiveness. Often he would drop by my office early in the morning after a particularly trying day (for he always shared my concern over the solution of difficult problems even though we did not always agree on the best solution), or after a faculty executive committee meeting in which there had been stormy differences of opinion. Without coming to the point directly, he would tell a story about some mountain character in Burke County or some historical figure in North Carolina, or quote a verse from the Bible, any one or all of which would be pertinent to a possible course of action or a decision which would be right and reasonable.

This has always been typical of Ross. He is so kind and gentle that he could never bring himself to “give anybody hell” even when the person deserved it. He sought to achieve the desired goal through a gentler and more indirect approach.

Some months ago an able alumnus of the medical school expressed, in a letter, his appreciation and gratitude for another member of the medical faculty who was leaving his post. The following paragraph is so very appropriate for Dr. Ross, and expresses so well the sentiments of his students, house staff, and colleagues, that I should like to quote it.

“He gave the department its character and personality. I'm sure someone can be found who can run the department with his head but he (Dr. Ross) ran it also with his heart.” I hope the new chairman will remember this.

And so, “Daddy” Ross, since we have drunk toasts in honor of your many and lasting contributions to the advancement of your specialty and to medical education, we salute you now, *Admiral* Ross, as the senior officer present. Thank heaven, you are not retiring! We all look forward to enjoying with you your enviable and well merited position as an elder statesman in your specialty, as a senior member of this medical faculty, and as a wise and knowledgeable consultant who still has important work to do in medicine and in the University's relations in North Carolina.

The Living Past

F. BAYARD CARTER, M.D.

DURHAM

We all believe in the present with a little doubt, believe in the future with a little fear, and believe that the past will come again. The past will never come again. However, those of us who had the privilege of sharing the past with Robert A. Ross have had a priceless experience which can never be explained, evaluated, or forgotten. He was the true *frater in urbe* and *frater in facultatus*.

To review for his friends and colleagues Dr. Ross's activities would be redundant. A brief summary, however, will show the quiet breadth of his interests and accomplishments. His contributions as the first qualified obstetrician and gynecologist in Durham cannot be magnified. His interest in, and his work for, the Salvation Army Home and Lincoln Hospital are documented. His efforts in founding the North Carolina Obstetric and Gynecologic Society, which he served as president, are expressed in the society as it stands today.

In 1930 and 1931 a doctor in obstetrics and gynecology in North Carolina had no society to which he might go for the necessary mental stimulus so important to his work, and for the continuation of his education. Dr. Ross's sensible vision led to the formation of a nucleus of men from which grew the South Atlantic Association of Obstetricians and Gynecologists. This association has grown to maturity and performs an important function in the South Atlantic states and the nation at large. Dr. Ross also served as president of this organization his foresight had created.

His early efforts in the formation of the Maternal Welfare Committee of the State Medical Society has produced true benefits in the betterment of maternal care in North Carolina. His interest in the Saluda Postgraduate Seminars was real and personal. To these he added the obstetric and gynecologic

seminars, which have reached far beyond the borders of this state to physicians who are eager to contribute to maternal as well as infant welfare in all parts of the South and nation.

His selection by the American Association of Obstetricians and Gynecologists to serve on its Choriocarcinoma Committee was a good one. This committee not only exerted a good influence on the care of patients with hydatidiform mole and with choriocarcinoma, but brought to us specimens from all over the country for teaching purposes and follow-up studies.

Dr. Ross's war service was a true exemplification of his life in general. He served with distinction and valor. There is no need for me to remind you that he is now a rear-admiral. His sensible, wise, and humane approach to our specialty assures the wives of servicemen that they will receive the same conservative and intelligent care so necessary in times of stress when the human values of reproduction are so often pushed into the background.

To the foregoing we add simply that Duke University saw fit to elevate him to a full professorship, but the University of North Carolina took him from us to organize and direct its Department of Obstetrics and Gynecology. We felt a tremendous loss but had to admit that if he had to go, it was just and right that he return to the alma mater for which he had a mature and deep affection and to which he has paid a deep-felt debt in terms of consistent service to human beings.

His staff was selected with true discrimination—a truly magnificent team composed of men of diverse talents. He did not, however, lose all contact with Duke. The Piedmont Obstetrical and Gynecological Society was formed to bring together faculty members, postgraduate scholars, and practitioners from the two universities and surrounding areas. The meetings of this society are classic examples of continuing education. The men-

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tal stimulation provided is a great antidote for professional stagnation. Certainly we would pay tribute to this society for the opportunity to "catch up" and "keep up" with the kaleidoscopic changes in our specialty and with related problems in other branches of medicine.

Dr. Ross's election as president of the American Association of Obstetricians and Gynecologists was a true measure of the esteem in which he is held by his national colleagues.

Finally, we must add the personal observations of his immediate colleagues and friends. It may well be said that Robert Alexander Ross added a spiritual dimension to our specialty by eradicating the commonly used pronoun "I" and substituting for it the so infrequently used pronoun "we." Any project which was good for obstetrics and gynecology was to him an obligation to be fulfilled with no regard for mental, physical, or financial stress.

His knowledge of the history of medicine, the history of obstetrics and gynecology, and the history of the South was a constant source of pleasure to all of us. He believed Cicero's plaint: "To be ignorant of the past is to remain a child." He also taught that progress is often based on retentiveness. When experience is not retained, perpetual immaturity results. In short, he subscribed to Santayana's concept that "those who cannot remember the past are condemned to repeat it."

His wit and humor carried us through some troublesome times, but he was always gentle and apt. He is a true raconteur, as we all know. Most important of all, he helped us understand that our chief obligations to pay to the future what we owe to the past.

You will forgive an old man for stressing the values *we* held through the years. To the old man, the past is still living, the present is so intense, and the future so imminent that he must guard his speech lest he be accused of pretence. Of this friend we can say that he is a man who loves life, lives it, and perfectly understands the use of it.

He is a true professional, both clinical and academic. He does not accept, without skepticism or dissent, all the stereotyped clichés

and the dubious assumptions which clutter our literature on medical education. He subscribes to Socrates' statement: "If you will be persuaded by me, pay little attention to me, but much more to the truth, and if I appear to say anything true, assent to it, but if not, oppose me with all your might, taking good care that in my zeal I do not deceive both myself and you, and like a bee, depart, leaving my sting behind."

His relations to his patients, friends, colleagues, and students are featured by kindness, bolstered by wisdom and the ability to give of himself in a natural, mature, and supportive manner. He walks with humility and in hope of helping others recognize the truth when they can think and meditate. He never approaches the morass of prejudice. He follows the old Grecian concept that "the unexamined life is not worth living."

He has never fought the future; he is busy with the present.

He is an individual who has remained individualistic and sane in all he does.

He has the capacity to maintain continuity with his earlier memories and to use them in his living.

His clear stream of reason does not become lost in the dreary desert of dead habit.

To close I quote the Oath and Prayer of Moses Maimonides because Dr. Ross has exemplified this Oath in his daily living and throughout his long and distinguished professional career.

O, grant—

That neither greed for gain, nor thirst for fame,
nor vain ambition,

May interfere with my activity.

For these I know are enemies of truth and love
of men,

And might beguile one in my profession

From furthering the welfare of Thy creatures.

O strengthen me,

That I might e'er unhindered ready be.

Grant energy unto both body and the soul

To mitigate the woes,

Sustain and help

The rich and poor, the good and bad, enemy and
friend.

O let me e'er behold in the afflicted and suffering,

Only the human being.

These words remind us of what one man can do as an individual, as a citizen, and as the "good physician." *Prome! Prome Prome!*

Testimonials, Testes, Testament

ROBERT B. GREENBLATT, M.D.

AUGUSTA, GEORGIA

It is given to few individuals to receive the plaudits and tributes of their friends while still actively laboring in the vineyards of their chosen field—in this case, the art of the practice of medicine. For almost three decades it has been my privilege to sit at the feet of a modern Gamaliel. With wonder and delight I caught the apt quotations from the Scriptures that embellished his discourses on medicine, human relations, and the philosophy of the living. I, therefore, owe a particular debt to Daddy Ross, for it is he who inspired me to study anew the Old and New Testaments. I hope that the dissertation that follows gives testimony to the fact that at least I have tried, even though failing miserably, to match his wit, the articulate phrasing, the *bon mot*, and his depth of understanding.

And Abraham said unto his eldest servant of his house, that ruled over all that he had, Put, I pray thee, thy hand under my thigh: And I will make thee swear by the Lord, the God of Heaven, and the God of the earth, that thou shalt not take a wife unto my son of the daughters of the Canaanites. . . .

Genesis 24:2, 3

Question: What relationship exists between taking an oath and the genitals? Why did young men of old swear on their manhood? Where did the custom derive of swearing an oath on some sacred or revered object—like the Bible?

Commentary: "I swear by Apollo the physician, and Aesculapius and Hygiea and Panacea and all the gods and goddesses. . . ." Thus the fledgling physician enters into a pact with mythological Greek gods—that he will abide by the ethical code prescribed for the practitioners of the healing art.

Human covenants with the gods date back

many millenia. When the Egyptians first began to record their codes and laws, their exploits and accomplishments, their fables and foibles onto papyrus, such agreements were also mentioned. According to the funerary papyri, Princess Nesi-Khensu, ten centuries before Christ, contracted with the god, Amen-Ra, to grant her certain favors in the Other World in return for her zeal and devotion. A thousand years earlier Abraham entered into a covenant with the Lord and sealed it through circumcision. Circumcision represented a holy bond between the Lord God and this man. It is of little surprise, therefore, that Abraham, in demanding an oath of his servant, bade him place his hand "under his thigh," just as today we place our hand over the heart in swearing allegiance to the flag. "Under the thigh" may well have been a euphemism.

Religion and Procreation

But why the reverence for the genital zone? It must be recalled that early religion was based on the generative impulse. The power of reproduction is of foremost importance and gives direction and consequence to religious fancies. Fecundity of man and beasts and fertility of the soil were the mainspring of his existence, and primitive man consecrated and sanctified the organ of reproduction. He interpreted the natural phenomena about him and wove them into the imaginative social fabrics of his civilization. Day and night, the waxing and waning of the moon, the recurrent seasons, the harvest, birth, death, rebirth—all fascinated him and gave meaning to his little universe. The fertility cult was grounded in the basic hopes, aspirations, and prayers of survival.

Abraham was strongly influenced by the cults which were an integral part of the way of life of the people about him and to whose culture he had been exposed. The very mode of administering the oath that he employed was not an isolated incident for later in Genesis we learn:

From the Department of Endocrinology, Medical College of Georgia, Augusta, Georgia.

Requests for reprints to Medical College of Georgia, Augusta, Georgia.

And the time drew nigh that Israel must die: and he called his son, Joseph and said unto him, If now I have found grace in thy sight, put, I pray thee, thy hand under my thigh, and deal kindly and truly with me; bury me not, I pray thee, in Egypt.

Genesis 47:29

The walls of Egyptian temples of antiquity bear witness to the importance of the phallic symbol in the thinking and mores of that period. Gods, kings, and great men frequently were depicted with penis erectus. Later, this image was translated into the obelisk, one of their popular forms of monumental design. The obelisks were much admired by the Roman emperors and many were carried off; today they may be viewed in Rome, Constantinople, London, and New York. One of the most famous, built by Rameses II at Luxor in Egypt circa 1250 B.C., was transported to Paris in 1831 and erected in 1836 in the Place de la Concorde.

But the biggest obelisk of them all was built as a testimonial to "the father of our country," George Washington. The Washington monument measures over 555 feet in height and over 55 feet at the base. It is indeed a fitting memorial to a great man who was every inch of a man. Some of his peccadillos have been forgotten even though a few of his premarital and extramarital exploits are on record. There is, in the archives of the University of Virginia library, a letter in which Jefferson invites George Washington to spend a few days at Monticello with the promise that a pair of choice virginal slave girls would be available. Whether Washington accepted the invitation, I do not know.

Oaths and Covenants

Embedded in the cultures of various peoples in widely dispersed areas of the world is a relationship between an oath and the genitals. For centuries in the Western World man took an oath "on his manhood," and indeed the Latin word *testes* is defined in Webster's International Dictionary as being a witness to manhood. The verb "to testify" is derived from the Latin root *testis*. S. R. Driver, in the Westminster Commen-

tary, suggests that the Australian Aborigines swore amity and willingness to aid one another by a man sitting on the other's thighs. It is recorded when the chief of the Sioux Indians demanded a count of the loyal warriors in his tribe, those who dropped their loin cloths did so in affirmation of their fealty.

It would appear that the custom of making a contract, taking an oath, entering into a covenant (the literal meaning of "testament") by reference to the groin (scrotum or testes) is an ancient and common one, at any rate not confined to the early Jews. It is to be found in a great number of primitive societies. This primitive form of oath-taking was long ago abandoned by the Jews and was replaced by swearing on a sacred object such as the scrolls of the Torah (the five books of Moses). Throughout the Anglo-Saxon world, taking an oath on the Holy Bible has become a thoroughly ingrained practice in courts of law.

In a search of the Scriptures it is of interest to learn that "covenant" appears many times in both the Old and New Testaments (King James Version) but "testament," which is used interchangeably with "covenant" in the New Testament, does not appear in the Old. The first mention of covenant is in connection with Noah:

But with thee will I establish my covenant and thou shalt come into the ark, thou, and thy sons, and thy wife, and thy sons' wives with thee.

Genesis 6:18

"Testament" first appears in the Gospel According to Matthew:

For this is my blood of the new testament, which is shed for many for the remission of sins.

Matthew 26:28

"Testimony," on the other hand, appears in both books.

And he gave unto Moses, when he had made an end of communing with him upon Mount Sinai two tables of testimony, tables of stone, written with the finger of God.

Exodus 31:18

History and Endocrinology

As we contemplate our customs and phrases, there appears to be a greater need for contemplation. "The more we question," to quote Saul Bass, "the more there is to question." The modern endocrinologist has a deep and abiding interest in reproductive physiology and the effect of the hormones of reproduction on the life of individuals and its impact on the race.

The course of history might have been far different if Hitler could have fathered children. There is substantial suspicion that Hitler was asexual—his relationships to the very few women in his life were said to be purely platonic. His lack of testicular vigor indirectly played havoc with his personality and as a consequence profoundly affected our civilization. It has been said of Goering, Hitler's chief lieutenant, that he behaved like an adult eunuch; he was fat and capon-like, a change that came, it is believed, after he

suffered trauma to his testes in an airplane accident soon after World War I. Frustrated, dejected, addicted to dope and to food, he could no longer sublimate his compulsion for revenge, to ravage the human race.

On the other hand, vigorous men like George Washington and Winston Churchill have been mankind's benefactors. Perhaps with Churchill's passing, an obelisk, too, will be built as a testimonial to a great and vital man—thus covenanting the hopes and aspirations of embattled and oppressed peoples the world over.

There is a story, apocryphal to be sure, relative to a young man from the mountains of North Carolina who still spoke an Elizabethan form of English. He applied for work in a nearby city and when asked to present his testimonials did so by giving evidence of his manhood. Testament, testimonial and testes, indeed, have been woven into the social fabric of our civilization.

Cancer of the Breast in Pregnancy

CHARLES H. PEETE, JR., M.D., HARRY C. HUNEYCUTT, JR., M.D.
AND WALTER B. CHERNY, M.D.

DURHAM

Although carcinoma of the breast is the most common cancer occurring in women, breast carcinoma in pregnancy is relatively rare.¹⁻⁴ It is a poorly understood problem about which much misinformation has been disseminated.

Opinion differs about the management of this problem, primarily because there has been no single reported series sufficiently large from which to draw meaningful conclusions. Discussion continues as to the role of x-ray therapy, the benefits of early termination of pregnancy and castration, and the indications for simple versus radical mastectomy.

Some authorities hold that breast cancer

coincident with pregnancy or lactation carries a grave prognosis, as evidenced by the low survival rates. However, successful treatment in instances of early diagnosis have been reported. Therefore, it would seem important to review this problem, considering the facts which provide a better understanding and the factors which could affect the prognosis.

Incidence

The incidence of carcinoma of the breast in pregnancy is relatively low; yet a closer study of the statistics discloses that the two conditions coexist more frequently than is generally believed. It has been estimated that one of every 35 cases of breast cancer, or one in every three occurring during the child-bearing age, will be complicated by pregnancy. On the other hand, the obstetrician's chance of seeing such a case is approximately 3 in 10,000 pregnancies. Obviously this is a problem which must be studied by examining the statistics from several hospi-

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Read by Dr. Peete before the Robert A. Ross Obstetrical and Gynecological Society, University of North Carolina School of Medicine, Chapel Hill, December 4, 1965.

Request for reprints to the Department of Obstetrics and Gynecology, Duke University Medical Center, Durham, N. C. 27708.

Table 1
Incidence of Pregnancy and Lactation in Patients with Breast Carcinoma

Year	Author	Total No. Cases	No. Cases Occurring in Pregnancy	Per Cent
1937	Harrington	4,628	92	1.9
1955	White, T. T.	43,931	1,258	2.9
1958	Treves & Holleb	579*	78	13.4
1961	Montgomery	4,959	70	1.4
1962	Westberg	25,139	757	2.9
1963	Rosemond	7,381	77	1.1

*Age 35 or younger

tals and clinics rather than by any single study.

In 1955 White⁵ compiled a total of 43,931 cases of carcinoma of the breast reported by 29 physicians. In this series, pregnancy or lactation was a complication in 1,258 (2.9%). Other authors^{2,3,6-8} reporting collected statistics have found the incidence of pregnancy or lactation among patients with breast cancer to vary from 1.1% to 2.9%. In 1958 Treves and Holleb⁷ reported a series of 179 breast cancers in women 35 years of age or younger, 78 (13.4%) of which occurred during pregnancy or lactation.

The obstetrician views the incidence of breast carcinoma in pregnancy a bit differently. White and White,¹ in a review of the world literature, found 93 patients with breast carcinoma among 300,860 pregnant women—an incidence of about 3 per 10,000 pregnancies. In our small series there were 14 patients with breast cancer among 35,983 deliveries during the period 1931 through 1964, for an incidence of 3.8 per 10,000 pregnancies.

Hormonal Mechanisms

In 1880 Samuel Gross⁹ wrote: "The rate of growth is not influenced by the early age of the patient. When, however, carcinoma appears during pregnancy, or during lactation, its growth is wonderfully rapid and its course excessively malignant." Because most reports subsequent to this time have emphasized the effects of pregnancy and have implicated the high estrogen levels and other hormonal factors, it becomes necessary to review the various endocrine factors.

The removal of the ovaries was advocated for cancer of the breast in premenopausal women more than a half a century ago by

Beatson.¹⁰ Thus, it has long been recognized that certain tumors of the breast in younger women depend on estrogen secretion. Later, when androgen became available for therapy, it was found to be antagonistic to estrogen in certain situations and was thought to be useful in the control of carcinoma of the breast. Loesser¹¹ and Ulrich¹² reported favorably on the administration of testosterone in the treatment of this lesion. Experimental studies (Twombly¹³) support the impression that the physiologic and hormonal changes which occur in pregnant women stimulate the growth of carcinoma of the breast, thereby producing a highly virulent course.

From experimental work in the mouse, Jull¹⁴ suggested that cancer of the breast may be either of two types—one stimulated by estrogen, the other by progesterone. Thus the type of cancer arising in any individual is determined by the hormonal conditions existing in that person. On the other hand, persons exposed to a breast carcinogen may not develop cancer because their hormonal status is unfavorable to that particular carcinogen.

Consider, now, the rationale behind the hormonal control of mammary cells in patients with metastatic breast cancer.

The pituitary gland exercises control by means of two main axes, pituitary-ovarian and pituitary-adrenal.¹⁵ Ovarian production of estrogen is controlled by FSH (follicle-stimulating hormone). Adrenal production of cortisol (hydrocortisone) and estrogen is dependent upon ACTH. In turn, the target hormones reciprocally control the elaboration of the pituitary hormones. Of much importance is the fact that although cortisol depresses the release of ACTH, it stimulates the production of gonadotropins. Therefore, the level of circulating estrogen can be altered by

Table 2
Incidence of Breast Carcinoma Among Pregnant Women

Year	Author	No. Pregnancies	No. Breast Cancers	No. per 10,000 Pregnancies
1955	White, T. T.	161,624	49	3.0
1956	White & White	300,860	93	3.1
1965	Duke series	35,983	14	3.8

procedures or agents which affect either or both of the axes.

What alterations are produced by these procedures?

1. *Oophorectomy*. Removal of the ovaries eliminates the major source of endogenous estrogen, but also removes the normal inhibition exercised by ovarian estrogen on the pituitary. Thus the titer of gonadotropins rises and the elaboration of estrogens from the adrenal cortex is increased.

2. *Oophorectomy and adrenalectomy* remove the two natural sources of estrogen. The resultant high level of gonadotropins (caused by the absence of endogenous estrogen and by the administration of corticosteroids required after adrenalectomy) may stimulate the production of estrogen from accessory adrenal tissue or from the undifferentiated retroperitoneal mesenchyme along the genital ridge.

3. *Hypophysectomy* removes the source of gonadotropic, adrenocorticotrophic, and mammatropic hormone production. If ablation is incomplete, the exogenous corticosteroid needed to sustain the patient may lead to stimulation of gonadotropins and the subsequent release of estrogen from ovarian, adrenal, or extra-adrenal sources.

4. *Androgens*. The administration of androgens inhibits the production of gonadotropic hormone and thereby diminishes the stimulus for estrogen production. Exogenous androgens, however, can be metabolized through a stage of estrogen by-products which may offset the desired inhibition of endogenous estrogen.

5. *Estrogens*. When exogenous estrogen is given, gonadotropin is inhibited and thus the production of endogenous estrogen is diminished. However, these agents may be metabolized into biologically active estrogen and thereby counterbalance the inhibitory effect on gonadotropin.

6. *Corticosteroid administration* provides

pituitary depression of ACTH and inhibits the release of all endogenous adrenocorticosteroids, including estrogen from the adrenal. The gonadotropins, however, are stimulated, and in turn the production of estrogen by the ovaries is increased.

Review of Duke Series, 1931-1964

Fourteen patients with carcinoma of the breast in pregnancy were seen in the Duke University Medical Center between 1931 and 1964. Excluded from this discussion are those patients who became pregnant after being treated for carcinoma. No patient with breast carcinoma complicating pregnancy was recorded until 1943, twelve years after the hospital was opened.

Age. The majority of patients were between 30 and 40 years of age. The youngest patient was 24, and the oldest 46.

Early diagnosis and delay in treatment

All writers on this problem have stated that the only possibility of cure lies in early diagnosis and prompt treatment. Waxman and Fitts¹⁶ have stated more emphatically that the prognosis is worse in patients with symptoms of more than one month's duration than in those with symptoms of shorter duration. Westberg⁶ reported that the diagnosis was made two months later in pregnant patients than in nonpregnant ones.

The physiologic engorgement, hypertrophy, and increased vascularity during pregnancy and lactation often make it difficult to palpate the small or deeply placed tumor until it reaches a substantial size. Another complicating factor in pregnancy is the high incidence of an inflammatory type of carcinoma which mimics the more common mastitis in pregnancy. An unfortunate delay in diagnosis results.

It behooves all obstetricians to examine the breasts carefully at the time of the patient's first visit, to re-examine them frequently, especially when any area is suspect, and to

Table 3
Results of Radical Mastectomy With Interruption of Pregnancy

Patient	Age (Years)	Date	Duration of Pregnancy (Weeks)	Delay in Operation (Months)	Metastases	Other Treatment	Results
1.	33	1949	12	12-18 mos	None	Irradiation to axilla	Alive 15 yrs 8 mos
2.	35	1952	13	7 mos	nodes Axillary		Died 2 yrs
3.	24	1955	8	3 mos	Axillary nodes	Irradiation to axilla	Alive 9 yrs 11 mos
4.*	38	1959	5	6 mos	Axillary nodes	Irradiation to axilla; testosterone	Died 18 mos
5.	33	1961	14	1-2 yrs	None		Last seen 3 months after operation
6.	33	1963	6	3 mos	Axillary nodes	Pituitary ablation, June, 1965; chemotherapy, July, 1965	Alive 2 yrs 1 mo
7.**	30	1964	14	?	Lungs, axillary nodes	Irradiation to axilla	Alive 1 yr 3 mos

*Biopsy only; lesion inoperable

**Simple mastectomy only

perform biopsies on suspected lesions. All patients should be instructed in the art of self-examination and advised to report any questionable lump immediately.

In this series, the delay in diagnosis, both patient and physician, varied between three months and one to two years. In larger series, White⁵ reported the average delay by the physician alone as 3.1 months. Bunker and Peters¹⁷ found that in less than one third of the patients was the diagnosis confirmed within three months, and only 10 of the 150 cases were diagnosed within one month after discovery of a lump.

Management

There has been much confusion concerning the proper management of breast cancer in pregnancy. Some surgeons have considered the presence of pregnancy or lactation a contraindication to radical surgery before the pregnancy is terminated. The majority, however, feel that radical mastectomy should be the primary treatment regardless of the state of pregnancy. There has also been considerable debate about the advisability of interrupting the pregnancy.

In this series of 14 patients, radical mastectomy was considered the treatment of choice. Eleven patients underwent this procedure, 2 others had inoperable lesions when first seen, and one of these underwent simple mastectomy for relief of pain. One other patient was seen in consultation only and was advised to have a radical mastectomy.

For purposes of discussion these cases may be divided into two groups: those in which the pregnancy was interrupted (Table 3) and those in which it was not (Table 4).

Pregnancy was interrupted in seven patients—by surgery in six and by irradiation to the pelvis in one. Among these, the longest duration of pregnancy was 14 weeks. Five patients were found to have axillary node metastases and four received postoperative irradiation to the axilla. Only two patients have lived five years or more, and one of these had node metastases. One patient received testosterone because of recurrence, and another received chemotherapy and underwent pituitary ablation two years following primary treatment.

In seven other patients who had been pregnant for 24 weeks or more, the pregnancy

Table 4
Results of Radical Mastectomy Without Interruption of Pregnancy

Patient	Age (Years)	Date	Duration of Pregnancy (Weeks)	Delay in Operation (Months)	Metastases	Other Treatment	Results
1.	38	1943	29	6	Axillary nodes	Irradiation to axilla	Alive 20 yrs 5 mos
2.	35	1947	30	10-11	None	Irradiation to axilla	Last seen July, 1952 (4 yrs 10 mos)
3.	33	1948	7	3	?	Examination only	Unknown
4.	32	1949	24	3	None		Alive 14 yrs 1 mo
5.	31	1955	32	10	Axillary nodes	Irradiation to axilla	Died 2 yrs 6 mos
6.	46	1959	32	8	Axillary nodes	Irradiation to axilla, 1959; oopho- rectomy, 1962	Died 3 yrs 3 mos
7.	29	1963	Term	?	Axillary nodes	Hysterectomy, bilateral, surgical oophorectomy; interrupted pregnancy 1964	Died 1 yr 5 mos

was not interrupted. One patient seen in consultation and advised to have radical mastectomy was lost to follow-up. Four patients were found to have axillary node involvement. Of the two patients who were free of metastasis, one is living 14 years after operation; the other was lost to follow-up approximately five years after operation. One patient who had positive axillary nodes is alive 20 years after surgery. Four patients received postoperative irradiation to the axilla. Only 2 of the 14 patients underwent postoperative oophorectomy, and both of these were in the group whose pregnancies were not interrupted.

Discussion

Therapeutic factors which must be considered in the prognosis are termination of pregnancy, postoperative x-ray therapy, suppression of ovarian function by operation or irradiation, the need for pituitary ablation and or adrenalectomy, and the use of testosterone and chemotherapy.

1. *Interruption of pregnancy.* The advisability of therapeutic abortion in the early stages of pregnancy in patients with breast carcinoma has been questioned by many

authors. White,⁵ Westberg,⁶ Bunker and Peters,¹⁷ and Miller¹⁸ were unable to show that therapeutic abortion had any definite influence on the course of the disease. Our results would seem to confirm their opinion. Adair,¹⁹ however, has reported a slightly better survival rate in those patients whose pregnancy was interrupted.

2. *Postoperative irradiation to the axilla.* Oft-quoted five-year survival rates in patients with cancer of the breast are 25% for those with positive axillary nodes, 75% for those with negative nodes. Bunker and Peters¹⁷ report rates of 30% and 50% respectively in pregnancy. White⁵ in a report of 806 patients, noted five-year survival rates of 7% in those with node involvement and 20.7% in those without node involvement. Harrington² reported rates of 8.9% in those with positive nodes and 64.5% in those with negative nodes.

The treatment of metastatic carcinoma poses a difficult problem. In almost all patients the local lesion and metastases should be treated by irradiation despite pregnancy. X-ray therapy, however, is not generally employed if no axillary metastases are demonstrable at the time of operation. In these

cases, therapy is withheld until evidence of recurrence is noted. Paterson²⁰ has noted that even though the disease recurred earlier in patients not given irradiation immediately, the five-year survival rate was the same when irradiation was delayed. Treves and Holleb⁷ and Randall²¹ feel that postoperative irradiation, even in the presence of positive axillary nodes, has no influence on the survival rates.

Cavanaugh²² doubts that irradiation given immediately after surgery or later for recurrences or when the lesion is inoperable, has a significant role in the cure of patients. Reports of radiation therapy alone are scarce, and there is no evidence that it can compete with radical surgery in terms of efficacy. One wonders, too, whether it is logical to submit all patients to the hazards of irradiation if local recurrences develop in no more than 10% to 15% of the cases.

3. *Suppression of ovarian function.* Dreser²³ first reported in 1929 the value of roentgen sterilization for the treatment of bony metastases and noted objective healing of bony lesions three years following operation. Similar isolated reports have been made, but most authors (notably Randall²¹ and Bunker and Peters¹⁷) consider the evidence insufficient to prove that oophorectomy delays or prevents metastases or affects the rate of survival. Kennedy²⁴ concluded that castration resulted in some delay of recurrence but had little effect on the length of survival following the primary treatment.

On the other hand, Treve and Finkbeiner²⁵ and Taylor²⁶ hold that total oophorectomy may benefit the patient with advanced cancer of the breast, and report a higher remission in those who underwent mastectomy two years prior to castration. For remissions to occur, the tumor must have the capacity to respond to estrogen withdrawal, the ovaries must be physiologically active, and oophorectomy must depress the estrogen level below a critical balance. Bunker and Peters¹⁷ reported that of 41 patients castrated, 32 had metastases, but none demonstrated any measurable improvement following surgical castration. Taylor,²⁶ however, reported that

29% of the patients showed objective regression six months after oophorectomy.

4. *Chemotherapy.* Clinical trials with various steroid and chemotherapeutic agents continue with the hope of achieving more effective palliation in patients with advanced carcinoma. The carcinostatic drugs have proved useful in a variety of ways. Shingleton²⁷ has investigated the use of various alkylating agents, including nitrogen, cytoxan, and ThioTEPA. The latter agent apparently has the widest application. Of 555 patients receiving this drug, 25% showed an objective response and 25% showed subjective improvement. Nitrogen mustard has been beneficial in patients with pleural effusion. Further observations must be made before it is possible to predict the exact role of chemotherapeutic agents in the treatment of carcinoma of the breast.

5. *Androgen therapy.* Haagensen²⁸ considered androgen therapy an important supplement in the management of breast carcinoma. This therapy should not be used, however, until both surgery and irradiation have been used to their full extent. Androgen is indicated (1) for the relief of pain arising from bony metastases only when irradiation will no longer control them, and (2) in women less than 60 years of age with soft tissue metastases no longer controlled by irradiation. The effectiveness of androgen therapy increases with the length of time following menopause and with the location of the metastases.

In its Report to the Council by the Committee on Research of the American Medical Association in 1960,²⁹ a series of 944 women with metastatic carcinoma of the breast treated by androgens and estrogens is discussed. Among 580 patients who received androgen, objective regression was noted in 20% of the premenopausal patients and in 21% of postmenopausal patients.

6. *Adrenalectomy-Hypophysectomy.* After an initial favorable response to surgery followed by relapse, some clinicians feel that adrenalectomy is indicated. When successful, this procedure can produce a dramatic response. Fifty per cent of patients with hopeless extension of the disease may obtain

objective remission for as long as 14 months, and some have survived for as long as 19 months.²⁰

Hypophysectomy²¹ is an alternative procedure, and objective remissions have been reported in about the same number of patients and for the same duration as with the use of adrenalectomy. Taylor²⁶ has reported objective regression of recurrent tumor in 28.4% following adrenalectomy and in 32.6% following hypophysectomy.

Hypophysectomy is an extremely serious operation. In general it is regarded as last-ditch therapy and is infrequently advised.

Summary

1. Fourteen breast cancers found among 35,983 pregnancies are reported, an incidence of 3.8 per 10,000 pregnancies.

2. Factors governing hormonal control and mechanisms are discussed.

3. Radical mastectomy is the treatment of choice and may be performed at any stage of pregnancy.

4. Interruption of pregnancy offers little improvement in the over-all prognosis.

5. Early metastasis is common and the over-all prognosis is poor.

6. The use of irradiation, suppression of ovarian function, chemotherapy, androgen therapy, adrenalectomy, and hypophysectomy in the management of breast carcinoma in pregnancy are discussed.

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Modern Obstetric Management of the Rh Problem

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The Rh-negative obstetric patient becomes immunized by exposure to Rh-positive erythrocytes—usually those of an Rh-positive offspring which cross the placenta during pregnancy or are exposed to the maternal blood during the second and/or third stages of labor. Occasionally immunization occurs apart from pregnancy by the transfusion or intramuscular injection of incompatible blood. Generally the degree of immunization is more severe when caused by blood transfusion, because of the massive infusion of antigen.

The Nature of the Rh Problem

The Rh problem usually develops when an immunized Rh-negative mother bears an Rh-positive child. The maternal anti-D (Rh₀) antibodies freely cross the placenta and react with the Rh-positive erythrocytes of the fetus. This reaction causes a hemolytic anemia in the fetus, which in extreme cases results in heart failure and may terminate in uterine death. More frequently the infant is delivered and manifests a rising level of bilirubin due to the hemolytic anemia.

Fetal risk

There are thus two distinct risks to the fetus: (1) the risk of anemia *in utero* and—if the level of maternal antibody is sufficiently high—heart failure, hydrops, and intrauterine death; and (2) the risk of hemolytic disease of the newborn, with a rising level of bilirubin in the blood stream and the attendant danger of kernicterus. The latter does not develop *in utero*, because the bilirubin and other products of the hemolysed red cells can usually be cleared through the placenta into the maternal circulation. After

birth the fetus is “on its own,” so to speak and must rely on its own liver for the conjugation and excretion of the pigments. As a rule the anemia and the hyperbilirubinemia can be corrected by exchange transfusions. It is important to recognize that the premature infant differs from the full-term infant in susceptibility to neurologic damage that may result from an elevated level of bilirubin. The former may not be able to tolerate temporary levels as high as 15 mg/100 ml, which may have no significant effect on the full-term infant.

It was believed at one time that if the erythroblastotic fetus could be delivered alive, its life could be sustained by exchange transfusions. Time soon proved, however, that death could still result from the complications of prematurity, or in fact from the transfusions themselves. One of the serious complications of prematurity is the development of the respiratory distress syndrome, which in 20% of the cases in which it occurs produces serious neurologic sequelae. It may, of course, be necessary to terminate the pregnancy prematurely, but we must first use all our resources to make certain that fetal erythroblastosis is actually present.

Incidence

The magnitude of the Rh problem can be stated with considerable accuracy; however, it depends to some extent on the racial or ethnic composition of the population concerned. About 15% of the white race as compared with about 1% of the yellow race is Rh-negative. The incidence is also much lower in the Negro and somewhat lower in the Puerto Rican.

Our experience at New York Hospital for the year 1962 is as follows: In a total of 4,768 deliveries, 617 of the mothers were Rh-negative—about 13%. About 20% of our patients are Negro or Puerto Rican—which ex-

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plains why our figure is lower than the estimated 15% of an all-white population.

Of these 617 women there was evidence of immunization against the Rh factor in 52. This means that 8.4% of the Rh-negative women were immunized. Disregarding parity, then, an Rh-negative woman on our service was subject to a 1 to 12 risk of immunization. Expressed in terms of the nearly 5,000 women admitted to the service, the chance of being immunized to the Rh factor was approximately 1.1%.

Perinatal mortality

Perinatal mortality (stillbirths plus neonatal deaths) is generally estimated at about 25% to 30% in Rh negative immunized patients. As will be indicated later, the employment of amniocentesis may be able to reduce this figure by about one third. Another factor that must be considered is also shown by our 1962 data from the New York Hospital. Among the 52 immunized pregnancies, the total perinatal loss was 12 infants, or 23%; however, in only 43 of the 52 patients was the offspring Rh positive. On this basis, the 9 infants who were Rh negative were subject to no risk from this disorder, so that the true perinatal mortality among the 43 immunized patients who had Rh-positive infants was 28%.

One other point should be clarified at this time. A somewhat prevalent misconception is that the first immunized pregnancy is not a serious consideration and involves little risk to the fetus. Again utilizing our 1962 statistics, Erlandson¹ found that in one half (six) of the perinatal deaths, there was no history of previous births of erythroblastotic infants to support the possibility of serious disease in the present pregnancy. In four of the six cases the present pregnancies were the first known to be immunized, and in the other two, although confirmation was not available, the evidence also strongly suggested that this was the first immunized pregnancy. Furthermore, study of the remaining cases indicated that three deaths had been preceded by a first immunized pregnancy that terminated in a stillbirth or the delivery of a severely affected child. Thus 9 of

the mothers involved in the 12 perinatal deaths of 1962 gave evidence of a first Rh pregnancy that culminated in disaster.

Considerations Governing Management

These data support the practice of routinely determining antibody titers in all Rh-negative women early in pregnancy, at four-week intervals during the last trimester and even more frequently when antibodies are detected. On our service the sera of all antepartum patients are tested for ABO and Rh antibodies. A screening test for antibodies is performed with the ficin and antiglobulin techniques using a standard cell (OR₁R₂). If immunized, the antibody is further identified with a commercial cell panel. The best reacting cell is used for all subsequent tests.

Titer determinations of antibody concentration in maternal sera have their limitations. In general, low titers (up to a dilution of 1:32) are of value. High titers in women previously immunized are useless. Thus a titer of 1:64 in a first immunized pregnancy may be indicative of a seriously affected infant and an indication for amniocentesis or termination of the pregnancy depending on fetal age. On the other hand, unusually high titers (above 1:512) in patients previously immunized may give no indication of the condition of the fetus. In such instances, to terminate the pregnancy would be entail the risk of unnecessarily subjecting an Rh-positive, perfectly healthy infant to all the dangers of prematurity. If the child dies—as the result of prematurity or respiratory distress syndrome, for example—the retrospective impact of the iatrogenic situation would be devastating.

The management of the Rh-positive pregnancy thus requires extreme skill. In the light of present knowledge, the major problem is to allow the fetus to gain as much maturity as possible but not to become severely affected or die *in utero*. Over the last two decades serial antibody titer determinations, obstetric history, medical or obstetric complications, the zygosity of the husband, fetal size, and the estimated date of confinement (and more recently, to a limited extent, spectrophotometric studies of the amniotic

fluid) have been the principal factors considered in planning the optimal time for delivery. By terminating pregnancy prematurely at 36 to 38 weeks, the perinatal mortality due to erythroblastosis fetalis was significantly decreased. Unfortunately some Rh-negative infants were delivered dangerously early and exposed to the complications of prematurity which in some cases were fatal. On other occasions the fetuses were more severely affected than was anticipated and died because of irreparable damage. In some instances the fetus died weeks or even days before the scheduled premature termination of pregnancy. In short, an accurate means of determining the fetal condition was lacking.

Amniocentesis and Spectrophotometric Scanning of Amniotic Fluid

For many years obstetricians had noted that the amniotic fluid was stained with bile when the infant was affected with erythroblastosis fetalis. In 1965 Bevis² reported that in such cases the amniotic fluid contained increased blood pigments, believed to reflect increased destruction of erythrocytes. Since that time Walker,³ Liley,⁴ Freda,⁵ and others have reported large series of cases in which analyses of the amniotic fluid were used to predict the severity of disease in the fetus.

The technique of amniocentesis was outlined in detail by Queenan and Adams.⁶ It has been used more than 400 times in the management of Rh problems at the New York Hospital and the Greenwich Hospital Association, Greenwich, Connecticut, and has proved useful in the assessment of the condition of the fetus in Rh-sensitized patients.

The initial procedure is generally performed at about the twenty-eighth or twenty-ninth week of gestation. It may be done earlier or later as indicated by the laboratory data, history, and clinical history. It is then repeated at weekly or bi-weekly intervals until delivery, depending upon the degree of deviation from the "normal" amniotic fluid bilirubin curve.

In general, the procedure should not be done unless the antibody titer reaches a critical level associated with severe erythroblas-

tosis fetalis. The critical antibody titer will vary in each laboratory. At the New York Hospital the procedure is not done unless the anti-D titer is 1:32 or greater because lower titers have not been associated with intrauterine or neonatal death. In instances of high titers in previously immunized patients, the test is of course of great value and may be the most important factor in assessing the condition of the fetus.

Technique

Amniocentesis may be performed in the outpatient department. The patient is asked to remain in the hospital for at least one hour following the procedure. In more than 400 amniocenteses in our series, there have been no instances of premature labor, infection, or maternal hemorrhage. Overnight admission was routine in our early experience, but more recently has been considered necessary for precautionary reasons on only a few occasions.

The amniocentesis tray contains the following equipment:

1. A clamp and sponges for sterile preparation of the abdomen.
2. Four towel drapes.
3. A 3.5-inch No. 22 spinal needle with stylus.
4. A brown bottle for storage of the fluid.

Details of the technique with illustrations have been published by Douglas and Stomme.⁸ Careful evaluation of the maternal abdomen and fetal position are essential before the procedure is attempted. The vertex position offers two favorable sites for aspiration of the fluid. If fluid can definitely be palpated in the area posterior to the fetal neck, this is the site of choice. This location is favorable because the operator can be relatively certain of avoiding the placenta if the fetal skull can be palpated with ease. In addition, the needle may be directed away from the fetus.

If the patient is obese or if accurate palpation of the fetus is not possible, the amniotic fluid is aspirated from the area of the fetal small parts. Since the placenta is located more commonly in the upper than the lower uterine segment, it is more frequently traversed when the needle is inserted at this

site. Under meticulous aseptic technique a 3.5-inch No. 22 spinal needle is introduced into the amniotic sac. The stylus is removed and the fluid aspirated. If the initial specimen is bloody, the syringe is changed to aspirate blood-free fluid.

The amniotic fluid may be colorless or straw-colored when the fetus is unaffected. When the fetus is affected, the color may range from straw color to yellow to yellow-green to yellow-brown with increasing severity of disease. Thus a general impression of the condition of the fetus can be gained from the color of the fluid. Since this visual interpretation is subject to considerable error, however, any therapeutic decision *must* be made on the spectrophotometric evaluation of the fluid. McRay relies to some extent on a chemical analysis which measures bilirubin and possibly other pigments. This technique has not been as successful in the experience of others, including Bonanes in our institution.

The amniotic fluid is stored in a brown bottle to protect it from light. The fluid is centrifuged immediately for 15 minutes to remove any erythrocytes, vernix or epithelial cells. If the erythrocytes are not removed, hemolysis may occur and alteration of the spectrophotometric curve (peaks at 410, 540, and 575 millimicrons) may cause problems in interpretation.

The fluid is filtered through Whatman filter paper and then analyzed by means of a continuous recording spectrophotometer (Perkin Elmer 202) with a linear scale. A scan is made from 350 to 750 millimicrons, recording the absorbence of monochromatic light against the wave length.

Methods of Evaluation

Several methods of evaluation (Walker,³ Liley,⁴ and Freda⁵) have been described. In general, Freda's method seems to have the most practical clinical application. Serial analyses are employed to ascertain the safety of allowing a gestation to continue, thus gaining valuable maturity. If the fluid is abnormal, the procedure must be repeated at weekly or biweekly intervals, depending on the severity of the curve. Of course, the results

could indicate the necessity for the immediate termination of pregnancy or an intrauterine transfusion of the fetus.

The spectrophotometric amniotic fluid scan is done from 350 to 750 millimicrons. A typical bilirubin "hump" begins at 375, peaks at near 450, and returns to normal at 525 millimicrons. A heavy line is projected from 375 to 525 millimicrons, demonstrating approximately the course of a normal amniotic fluid scan in the absence of bilirubin. An upright broken line is drawn at 450 millimicrons to show the deviation of this bilirubin peak from normal. The deviation, irrespective of the intensity, always occurs between 375 and 525 millimicrons.

The abnormal curves are graded by Freda⁵ according to their deviation from normal in optical density at 450 millimicrons.

1+	0-0.2
2+	0.2-0.35
3+	0.35-0.7
4+	0.7 or greater

Prediction of Fetal Outcome

If the amniotic fluid scan reveals a 1 plus deviation, the fetus may be Rh-negative or Rh-positive, but is usually not in danger of intrauterine death within the following two weeks. If the scan reveals a 2 plus deviation, the fetus is almost certainly Rh-positive and affected, but is not considered in danger of intrauterine death during the next one to two weeks. If the fetus is not undergoing progressive deterioration, the deviation from normal decreases for reasons that are not entirely clear. If a 3 plus abnormal curve is obtained, the fetus will undergo progressive deterioration and may die *in utero*, possibly within ten days. A 4 plus abnormal tracing means impending fetal death. Although our criteria of a 3 plus abnormal tracing is slightly lower than Freda's, the practicality of this method of predicting fetal outcome is proved by the large series he reported.

As previously stated, determination of antibody titers on maternal serum has a limited value. The titers are often useful, especially in a first immunized pregnancy or if there is a history of a previously mildly affected in-

fant and the titer remains below 1:32. The indications for amniocentesis are varied; they include a rising antibody titer, and a history of a previously affected infant (or infants)—ideally, very high titers or a history of intrauterine fetal death.

In an immunized obstetric patient with a heterozygous husband, serial antibody titers are unreliable for predicting the condition of the fetus. Amniocentesis, on the other hand, is quite accurate. With this information available, if the fetus is Rh-negative it benefits by not being subjected to a premature delivery. If it is Rh-positive the severity of its condition is assessed and it is allowed to gain valuable maturity. Repeated "taps" and analyses make it possible to follow changes in the condition of the fetus and take appropriate action before irreversible deterioration occurs.

Intrauterine Transfusion

In some instances amniotic fluid scan indicates rapid fetal deterioration at a stage of gestation too early for delivery (for example, 24 weeks). If the fetus were delivered it would almost certainly succumb to complications of prematurity, but if left *in utero* it would continue its downhill course of hemolytic anemia, heart failure, and death.

In October, 1963, Liley⁶ reported the first successful intrauterine transfusion. After withdrawal of the amniotic fluid, a radio-paque medium, diatrizoic acid,* was instilled into the amniotic sac. In addition to outlining the fetus, the contrast material when swallowed outlined the fetal gastrointestinal tract. Using this tract as a guide, Liley passed a needle through the maternal abdominal wall, the uterine wall, and into the fetal peritoneal cavity. Rh-negative blood was instilled into the cavity and was subsequently absorbed into the fetal circulation.

Our experience with intrauterine transfusion at the New York Hospital began in 1964 and the initial results appeared in 1965.⁹ Meperidine hydrochloride** (150 mg intramuscularly) pentobarbital sodium***

(100 mg per os), prochlorperazine**** (10 mg intramuscularly) are given to the patient as premedication one hour prior to the procedure. It is highly desirable that the patient and the fetus remain quiet during the transfusion. It may have to be delayed a few moments by movements of the mother, uterine contractions, or hyperactivity of the fetus. A more comfortable placement of the mother on the x-ray table will usually make it possible to proceed. By gentle palpation and auscultation, the operator determines the position of the fetus and the presenting part.

The patient's abdomen is prepared and draped under sterile conditions. Amniocentesis is performed and 20 cc of the fluid are removed. Twenty cubic centimeters of diatrizoic acid are then injected into the amniotic sac. This is important to assessment of the fetal condition. Scalp edema, protuberant abdomen, flaccidity of the extremities, and delayed swallowing are indicative of a severely affected fetus. If there is evidence of hydrops fetalis, the intrauterine transfusion is contraindicated, because the blood is not absorbed from the fetal peritoneal cavity.

After the instillation of the dye, lead markers are placed on the maternal abdomen in a position estimated to surround the fetal peritoneal cavity. An abdominal x-ray film is made. Swallowed contrast medium can be visualized in the fetal gastrointestinal tract and show where the needle should be directed to enter the fetal peritoneal cavity. The markers are removed and their sites designated by skin dye. The abdomen is then prepared and draped according to aseptic technique. A 20 cm No. 17 Tuohy needle with stylus is introduced into the amniotic cavity; free aspiration of the fluid indicates that the needle is in the amniotic space. The needle is advanced toward the estimated position of the fetal peritoneal cavity. In some instances fluoroscopy with an image intensifier has been useful in directing the needle.

As the needle passes through the abdominal wall of the fetus, a definite sensation is perceived by the operator. The needle's position is checked by injecting 3 ml of diatrizoic acid and taking an x-ray film. If the

*Diatrizoic acid (Hypaque-M75) Winthrop.

**Demerol, Winthrop.

***Nembutal, Abbott.

****Compazine, Smith, Kline and French.

needle is correctly placed in the fetal peritoneal cavity, the contrast material will assume a characteristic appearance as it runs over the surface of the gastrointestinal tract. A fine polyethylene catheter is threaded through the needle and the latter is withdrawn.

Type O, Rh-negative blood is prepared by drawing off 175 ml of plasma from a 500-ml unit of blood. One million units of aqueous penicillin are added to the loosely packed erythrocytes. The blood is then administered slowly through a donor set with a filter. If the fetus has reached 30 weeks' gestation, 100-150 ml of blood is infused, but if the fetus is less mature a smaller quantity is given. A fetus of 22 weeks' gestation will accommodate only 35 ml of blood.

Following an intrauterine transfusion the amniotic fluid often contains meconium and/or blood-breakdown pigments. It is therefore an unreliable index of fetal condition. The procedure must be repeated at 10- to 14-day intervals until delivery. It has been our experience that at the time of each subsequent transfusion, the blood from the previous transfusion is completely absorbed.

At delivery the fetus is often extremely anemic. Generally, more than half of the erythrocytes are traceable to intrauterine transfusion. In one instance where the fetus had had two intrauterine transfusions, studies of the cord blood revealed 5.8 gm of hemoglobin with 95 adult (transfused) erythrocytes/100 ml, as determined by the Kleihauer-Betke stain.¹⁰

Intrauterine transfusion by the technique described has certain obvious disadvantages. It involves probing with a sharp needle to find the peritoneal cavity of a fetus that sometimes makes quick and not always recognized changes of position. In order to obviate these disadvantages, other approaches have been explored. These include exposure of the fetus by abdominal hysterotomy, extracting the lower extremity and repairing the uterus. Another approach also employing abdominal hysterotomy is to insert a silicone catheter under direct vision into the peritoneal cavity of the fetus and leave it in place for subsequent transfusions. Both of these procedures,

used rarely, have almost always been followed by the onset of premature labor and death of the fetus.

Amniotic fluid analysis and intrauterine transfusion afford a new approach to the management of the Rh problem. Both procedures must be used judiciously; if they are so used, a significant decrease in perinatal mortality from erythroblastosis fetalis is possible.

Amniocentesis and the spectrophotometric examination of the fluid is a relatively new diagnostic procedure designed to complement existing practices. The information so gained permits the delivery of the erythroblastotic infant of appropriate weight and gestational age at the optimal time for survival. At birth the Apgar score, together with spectrophotometric determination, provides better prognostic information than the cord hemoglobin, Coombs test, and so forth.

Intrauterine transfusion carries with it an inherent risk of fetal death and should only be employed when otherwise a fatal outcome appears certain. The risk should be clearly understood by both obstetrician and parents. The cause of death often cannot be determined, but it is sometimes associated with insertion of the needle elsewhere than in the peritoneal cavity. The procedure is not indicated in the seriously affected infant who has already developed hydrops fetalis. In other words there is a "point beyond return," demonstrated by amniocentesis and an amniogram, which indicates scalp edema, ascites, and/or flaccidity of the infant.

It is obvious that the Rh problem has not been ideally resolved. The ideal, of course, would be prevention of the disorder. Freda and Gorman have effected passive immunity in male volunteers with Rh-negative blood in Sing Sing prison by inoculating them with high-titer anti-D globulin antibodies. Active isoimmunization did not develop in the subjects when they were injected with Rh-positive red cells at the same time; subjects in a control group did become actively immunized.

Freda and associates (Columbia University College of Physicians), Finn, Clarke, Woodrow and colleagues (University of Liv-

erpool, England), Chown and Zipursky (Winnipeg, Canada), Montague and Krevins (Johns Hopkins), Jennings (California), and Queenan (New York Hospital—Cornell Medical Center) are independently or collaboratively attempting an immunologic approach to the problem in the human female. Rh-negative primiparas were injected with high-titer anti-D gamma globulin following delivery. This caused a temporary passive immunity. Only active immunity to the Rh factor is dangerous to the fetus. The function of the injected antibody is to destroy all the antigenic Rh-positive fetal red cells that have entered the maternal circulation before they can cause isoimmunization by way of an antibody response that would be hazardous to the fetus in subsequent pregnancies. The gamma globulin is prepared from sera with an extremely high Rh titer.

The timing of the injection of antibody following delivery is based on the fact that the major fetal-maternal passage of blood occurs during labor and delivery. The Winnipeg investigators believe that at least some passage occurs before labor and for this reason have injected the antibody at three-week intervals during the last trimester of pregnancy. As yet there has been no evidence of anemia in any of the newborn.

The series, however, are small as yet and the supply of high-titer anti-D gamma₂ globulin is limited. Collected statistics compiled from the studies mentioned indicate that of 78 women treated, none have been found to be sensitized and all were free of circulating antibodies six months or more after delivery. In the control or untreated group, 18 among 94 patients are nonsensitized. Since the rate of spontaneous Rh im-

munization is only 10% in all parous Rh-negative women, a relative large number of treated and untreated subjects must be studied over a prolonged period before lasting conclusions can be reached. If the studies indicate success, this method could be used to prevent isoimmunization—in itself a most significant contribution to obstetrics and one that could mean the eventual elimination of the Rh problem as we know it today. It would not, of course, help those women who are already immunized.

Even if we eventually succeed in preventing the Rh problem, obstetricians will have to be concerned with amniocentesis, intrauterine transfusions, and possibly other modalities of treatment for the next two or more decades.

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Intense thinking is so destructive to health, that few instances can be produced of studious persons who are strong and healthy. . . . Man is evidently not formed for continual thought more than for perpetual action, and would be as soon worn out by the one as by the other.—William Buchan: *Domestic Medicine, or a Treatise on the Prevention and Cure of Diseases by Regimen and Simple Medicine*, etc. Philadelphia, Richard Folwell, 1799, p. 55.

Undergraduate Education for Specialty Practice

ISAAC M. TAYLOR, M.D.*

CHAPEL HILL

As one of our speakers remarked earlier, those who were responsible for arranging this program have shown remarkable sensitivity in selecting topics that reflect the interests and achievements of Dr. Ross. His splendid capacity as an obstetrician and gynecologist are attested to by the scientific papers included in the morning program. The afternoon session, on medical education, reflects his capacity and achievement as a teacher. This paper is directed to the subject, undergraduate education for specialty practice. For many reasons, I suspect that it would be more profitable if he were the speaker, for the subject is one to which he has devoted a major portion of his energies since I was literally in knee pants.

We at the University of North Carolina School of Medicine are embarking upon a review of our curriculum in the hope of producing a more meaningful experience for our undergraduate students—an experience that will stand them in good stead throughout their professional careers during the remainder of this century and the beginning of the next. At our present stage in this task, we are trying to think in generalities; to free ourselves as much as possible from the limitations of our own past experience; and to obtain a fresh perspective of our profession and of education for it.

In recent years it has become fashionable to revise medical curricula and introduce innovations. These endeavors make the more diffident of us teachers a little self-conscious as we look at our own schools and embark on our travail. Nevertheless, after more than half a century since the Flexner Report established what has become a standard curriculum for medical education, no

one can doubt that reexamination and reappraisal are needed.

Problems Facing Medical Education

Medical education today confronts many problems. The first of these is the information explosion. It is a truism that one cannot possibly encompass in a medical curriculum all the knowledge and skills that are applicable to some aspects of medical practice, not to say indispensable to thorough competence in a specific area. We must, therefore, limit our expectations to the amount our students can assimilate during their medical school years.

Certain questions must be answered: Can we define the minimum amount of factual information which each student must master—a so-called core curriculum? If this minimum is defined, should it be the same for each student? Should we attempt to meet the increase in information by lengthening the period of formal education? Should we turn to early specialization so that all our graduating students will be learned in greater depth in a narrower field?

Two related problems pose vexing questions: the nature of future medical practice, and the nature of the society in which our graduates will be practicing their profession.

The population explosion is a real factor. The volume of anticipated medical practice demands careful consideration of how the new generation of physicians is going to satisfy the demands, and how the efficiency of the individual physician is to be increased. Should we emphasize the education of a variety of specialists who, by a collective approach, will deal with the total needs of the patient, or should we encourage the development of competent generalists who through more sophisticated knowledge, greater professional capacity, and improved facilities

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can provide for their patients a broader yet higher quality of medical care?

Sociologic and demographic factors also enter the picture. We are becoming an urban society, and with the agglomeration of the citizenry, the mechanisms for the delivery of medical care are changing. Doctors too, are moving to the cities and, in my opinion, at a faster pace than the population in general. As a result, rural areas are becoming increasingly deficient in available medical services, and no one seems to know what to do about it.

A favorable factor, of course, is improved transportation, which makes urban medical facilities more accessible to rural people. Two years ago I was seeing regularly, in our outpatient department, a patient from the Outer Banks of North Carolina. Faithfully, on a two-week schedule, he was on time for a 10 A.M. clinic. The automobile made this possible, but the fact that he had to drive 250 miles each way for his appointment is clear evidence that the automobile is not an ideal solution to the problem of local deficiencies in medical care.

Another factor of great, but as of now imponderable, significance to future medical practice is the clearly expressed intention of the public, represented by Congress, to bring the federal government actively into the delivery of personal medical services. For our present purposes, we need not discuss whether the effect will be good or bad. The important thing is that it will be major, and we must be alert to adjust our educational programs appropriately. Medicare; heart, cancer, and stroke centers; preventive care—who really knows what they will mean? From the educational point of view, I expect that one of the earliest and most important effects will be increasing pressure on our students and residents for specialty training.

A final major problem in medical schools today is that of striking a balance between research and teaching. As dean of an ambitious and forward-looking medical school and a long-time participant in federally sponsored research programs, I would stoutly deny that medical school research is or has been overemphasized. But I think it is clearly true

that undergraduate education has not received equally appropriate emphasis. It is not that the education of our students has suffered through neglect; on the contrary, I am certain that research has benefited teaching programs immensely. But I believe that the massive and overbalanced support of research has gradually changed the character of our medical schools in a manner which is less than optimal from the standpoint of the education of the physician.

Scientific Discipline

I would like to review briefly some points which I consider important in relation to the general objectives of medical education. Certainly medical practice must rest upon a scientific basis which becomes increasingly rigorous as research increasingly dispels empiricism. Medical schools must inculcate the habits of thought and study and critical appraisal which make possible continuing scientific practice. Our students must be imbued, moreover, with the humanitarian qualities which characterize the conscientious and competent physician. Most important, medical schools should provide the environment which fosters a genuine professionalism—that is, an environment in which the student develops a view of himself in relation to society that enables him to accept and discharge the responsibilities of his profession. I hope, by the way, that the latter will not be interpreted as an endorsement of the priesthood concept of medicine.

Freedom of Choice

In spite of the uncertainties about the future, the questions about the best way to teach, and the problems concerning the increase in information, there is, I believe, a second fundamental objective of undergraduate medical education which is most important. This objective is to bring the student, by the end of his medical school years, to the point where he has maximum freedom of choice in his future career. Given the first objective—professional competence and humanitarianism—it is the second objective which can most usefully guide us as we ponder our curriculum content and methods of teaching, and which is most important in

our consideration of undergraduate education for specialty practice.

How do we approach this objective? First of all, we must insist upon education in depth in the basic sciences of medicine. These include, in the modern context, not only the six classical sciences of the freshman and sophomore years, but also biostatistics and mathematics, the concepts and content of modern biology, and appropriate courses in the behavioral and social sciences.

Some will say this will burden still further the already overcrowded first two years. I acknowledge the danger, and it leads me to say that pre-medical as well as medical curricula must be considered in the discussion of medical education at any level. It is important to keep in mind that students entering college these days are often, though admittedly not always, much further advanced in mathematics, biology, chemistry, and physics than were students of earlier days. This advantage should be taken into account in prescribing medical school admission requirements. Moreover, the better preparation of some of our students should make it possible to offer a good deal of our basic medical sciences as part of the pre-baccalaureate rather than the medical school curriculum. General biochemistry, general physiology, and some aspects of anatomy could be properly so offered. Parenthetically, I am sure that recruitment for medicine of the better students interested in science suffers in colleges where really exciting modern biology is not a part of pre-baccalaureate experience. Eager students must see that applied biology, which in part medicine is, offers as much intellectual stimulation and reward as do physics or chemistry.

Next, in order to have maximum freedom of choice on finishing medical school, the student must have as broad an experience as possible in all the clinical disciplines. As an internist, my natural inclination is to consider that the medical clerkship is really the only clinical clerkship a student needs. My bad conscience about this parochialism was considerably relieved recently to hear an obstetrician say brazenly that, without question, the study of human reproduction alone

would adequately prepare any really competent student for whatever career he ultimately chose.

This kind of dedication is very good for the student, and I hope all our teachers feel the same, but the student should not be denied the opportunity to work and learn from as many different specialists as possible. Not only does he learn specific skills, a matter of secondary importance, but he has a chance to appraise the nature of the specialty, his own attitude toward it, and its relation to the generality of medicine. Postgraduate training is Dr. Thornton's assignment, but it is my opinion that for most students, wide experience in the various specialties is more appropriate to the undergraduate years than to the internship.

Returning to the point just made, I consider the medical specialist's role in teaching highly specialized skills secondary to imparting to the student general principles pertaining to the specialty and relating it to the rest of medicine. This is the dilemma of the practical versus the theoretical in our educational endeavor. Obviously a balance is required. In part, it should be decided by the student's interests. The most important thing is the personality of the teacher: his interest, enthusiasm, and standards of excellence contribute in a general way to the development of the student. Dr. Ross is exemplary of these qualities in the highest degree.

A second point about the role of specialists in undergraduate education is that they are best equipped to provide clinical teaching, bringing to the student, each in his own field, the most rigorous approach, the most specific experience, and the greatest depth of knowledge. It is often proposed that medical schools establish departments of general practice. Although there is value for students in preceptorships in general practice, I do not favor the establishment of such departments for the reason that the essence of general practice would be lost in the medical school setting.

General practitioners have made worthwhile contributions to medical education in the teaching hospitals, but I believe that this instruction should be given under the au-

spices of internal medicine or pediatrics. I would emphasize the importance of frequent contacts between students and physicians during their clinical years, particularly internists and family practitioners who are primarily engaged in practice rather than research and teaching. Such contacts will help to correct the over-balanced support of research of the past 15 years.

Changes in the Curriculum

I want to return now to consideration of changes in the medical school curriculum which may serve to meet the varied and in some respects conflicting aims of undergraduate medical education. To reiterate, we should first strive to see that the pre-baccalaureate years are used as efficiently as possible for instruction in the biological sciences. Second, we should maintain maximal flexibility in the medical curriculum itself. This is referred to by curriculum revisionists such as myself as "breaking the lock-step of medical education." I think it is crucial.

In the first place, it is unrealistic to expect the entire medical class to begin the course on September 15, 1966, and follow essentially an identical experience until graduation four years hence. The wisdom of varying the pace is manifest by the rather common experience that students with academic difficulties who repeat a year's work in the classical curriculum almost invariably succeed in graduating from medical school.

Third, I think each of us tends to overestimate what we have to teach in our several disciplines. Difficult as the task is, medical faculties must continually and critically re-evaluate course content in order to achieve a core of information of manageable size which will permit leisure in the curriculum for elective courses and independent study.

Finally, given an adequate core curriculum, students should be able to choose wisely and in the best interest of their own education from well planned and diverse elective courses. Flexibility in the medical curriculum has several merits. The student can set his

own pace; he can choose elective courses in areas where he is weak; students with varying premedical experience can be accommodated with greater facility and profit in the early medical school years; basic sciences and elective courses can be introduced in the clinical years at a time when the student may find them especially meaningful in the light of advancing clinical experience.

Students who can choose their specialties early are able to plan their medical school work more intelligently. To me an intriguing possibility of the more flexible curriculum in the light of advanced pre-baccalaureate scientific training is advancement of the entire educational process so that the senior year can be made much more like an internship than a clinical clerkship. Already in many schools selected senior students are able to serve with full confidence as substitute interns, and I think it not inconceivable that in some cases the internship year as presently arranged might be replaced by the first year of specialty residency training. This would be an important step in advancing training for specialty practice.

Summary

To summarize these remarks, a number of principles are offered as guidelines to revision of medical school curriculums. First the undergraduate years must provide education rather than training. The education must be broad yet rigorous. The attainment of special skills and technical competence should be done largely in the internship and residency. The specialist is essential, however, to undergraduate education, for he alone can bring to the student the depth of knowledge required in his own field.

The curriculum must give to the student the opportunity to see all areas of medical practice so that he may see how each relates to the other and to the whole, and thus be able to make for himself an intelligent choice as to a career. Finally, flexibility must be a key objective. Its attainment will provide, among other things, balanced education on the undergraduate level for specialty practice.

Residency Training in Obstetrics and Gynecology

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The wide diversity of opinions as to what an obstetrician and gynecologist should be complicates the discussion of residency training for this specialty. Every physician who is responsible for a residency program has his own ideas as to the education and training necessary to produce the desired product. There is obvious dissatisfaction with the present situation, and efforts have been made to study the many facets of post-graduate education in this specialty. As recently as November, 1965, the Inter-Society Conference on Residency Education, representing ten organizations, met in Chicago to discuss such varied aspects of the matter as:

1. Related basic science teaching in the residency program.
2. The 18 months obstetrics, 18 months gynecology division of clinical training.
3. Advanced clinical training and certification in special fields.
4. Research training in the residency program.
5. In-course evaluation of residency training.
6. Qualification of the program director and staff.
7. Ways and means of remedying educational deficits.
8. Methods of evaluation and review of programs.

The number and complexity of these problems suggest that it will take time to find answers to all of them. Thus I thought it might be more constructive to point out some of the areas which will determine the growth, direction, and influence of the discipline of obstetrics and gynecology in a changing world of medical education and patient care.

Attraction of Talented Students

Through a process of slow evolution the

discipline of obstetrics and gynecology is now considered one of five major departments in the organization of the clinical program of a medical school. This recognition is commendable and, I believe, deserved, but considerable effort will be required if our specialty is to be accepted and accorded the same status as that enjoyed by medicine and surgery.

In order to attract talented young men it is essential that members of the department have some direct contact with the student early in his medical course. This cannot be accomplished by an occasional formal lecture during the first two years of medicine (See Table 1).

Table 1

Clock Hours Taught by Clinical Departments in the First Two Years of Medical School

Department	Percent of Schools	Average	Range
Medicine	97	186	20-366
Surgery	69	46	10-126
Obstetrics	52	26	9-64
Pediatrics	37	26	4-63
Psychiatry	100	76	160
Radiology	34	15	3-70
Preventive medicine	39	59	16-173
History of medicine	11	24	11-60
Conjoint courses	39	100	6-354

Source: U. S. Public Health Service compilation from catalogs of 60 medical schools.

The present deficiency in personal contact becomes more serious with the present trend in medical education which permits the student to select earlier in his career the specialty he wishes to pursue and, by the process of election, to eliminate some of the traditional subjects now being taught to all students.

We have planned an experimental five-week course at the University of Virginia which will permit all the clinical departments more personal contact with the student in his second year. This course will be devoted to mechanisms of disease and physical diagnosis, and is so arranged that all clinical departments will participate. Traditionally, the

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introduction to clinical medicine has been conducted chiefly by the department of internal medicine.

The present limited contact with the student continues into the last two years of medicine (Table 2), and in some departments the

Table 2
Weeks in Clinical Subjects in the Last
Two Years of Medical School

Department	Weeks of Inpatient Training	
	Average	Range
Medicine	20	12-35
Surgery	17	8.5-24
Obstetrics	9	3-15
Pediatrics	9	4-19
Psychiatry	6	0.5-13

Source: U. S. Public Health Service compilation from catalogs of 43 medical schools.

student's first contact with obstetric or gynecologic patients occurs in his senior year. This actually means that some students have no contact with obstetric or gynecologic patients until the last few weeks of their undergraduate education. By this time most students have selected the field in which they wish to obtain additional training or post-doctoral education.

Emphasis on Teaching and Research

Not until recent years has obstetrics and gynecology been considered anything other than a patient-service department. This is an area in which we need not apologize, however, as witnessed by the improvements in maternal care and the significant reduction in maternal mortality, developments in preventive medicine which, if ideally utilized, would virtually eliminate deaths from cervical cancer, and the improvements in pre-operative and postoperative care with a marked decrease in morbidity and mortality rates.

More recently there has been greater emphasis on teaching and research, with realization of the tremendous opportunities they offer. In a recent discussion on "Surgical Teaching of the Undergraduate," Dr. Englebert Dunphy, past president of the American College of Surgeons, cited the surgical ward as the ideal place for the student to learn humility, responsibility, loyalty, and charity. Sir John Bruce, past president of the Royal

College of Surgeons of Edinburgh, speaking at the same conference, felt that this same area provided the ideal environment in which to expose the undergraduate to advances in medical science as well as the pathology and physiology of disease. Each felt that educators were missing a great opportunity in not taking full advantage of these possibilities. I believe that the statements also apply to obstetrics and gynecology.

In order to take advantage of these opportunities for undergraduate teaching, an adequate faculty is essential. In my opinion, the proposals for meeting faculty needs suggested for new medical schools by the Public Health Service in cooperation with the *Ad Hoc* Committee on Medical School Architecture of the Association of American Medical Colleges and the American Medical Association are totally unrealistic (Table 3). The

Table 3
Assumed Faculty

Department	Entering Class of 64 Students	Entering Class of 96 Students
Medicine	18	25
Surgery	15	21
Pediatrics	5	8
Obstetrics	3	4
Psychiatry	10	14
Radiology	5	7
Preventive medicine	4	6

Source: U. S. Public Health Service.

suggested size of the full-time obstetric and gynecologic faculty would relegate the department to a patient service, with little opportunity for development in teaching and research.

I am happy to note that Dean Taylor expects more of the department at the University of North Carolina, which I understand will have from eight to nine full-time faculty members. This obviously will require a larger budget than that enjoyed by this department in many other schools, which often must operate on the smallest budget of any major department in the medical school. Although the number of budgeted positions in obstetrics and gynecology has increased during the past five years, the increase is less dramatic than that seen in medicine, pediatrics, or psychiatry. Some 40 of the 563 budgeted positions in our specialty in the 84 schools offering a full four-year

Table 4
Residencies in Obstetrics and Gynecology

Approved Programs	Total Offered	Nonforeign Graduates	Foreign Graduates	Total Filled	Percentage Filled	Percentage of Foreign Graduates in Filled Positions
434 (377)	9/1/64 2,806	1878	622	2500	89	25
Total Positions Offered 1966-1967.....					2842	
Graduates 1964-1965					7409	

Source: Journal of the American Medical Association, vol. 194, page 771.

program are now unfilled. This is a serious problem in view of the fact that 14 additional schools have publicly announced their commitment to establish a new medical school within the reasonable future.

Regarding the importance of teaching, Dael Wolfe, in a recent article in *Science*, said: "The advantage that the researcher has over the teacher in gaining repute outside his own institution has been increased in recent years by the large amount of external money available for research, the national review system under which much of that money is granted, and the emphasis given research by federal agencies and universities." He observes that "Recent reports, comments and editorials from a variety of sources have warned that a better balance must soon be restored," and that the need is "for more emphasis on good teaching."

Challenges to Residency Programs

The 1965 Directory of Approved Internships and Residencies lists 377 approved programs in obstetrics and gynecology. In the majority of these programs the resident can complete his training with 18 months of clinical obstetrics and 18 months of gynecology in the usual period of three years. Eighty-four programs, as a result of limited clinical material or the desire to permit the resident some experience in related fields, require four years for completion and to meet the requirements for certification by the American Board of Obstetrics and Gynecology. In a day when time and speed seem so important, it might be mentioned that the four-year programs must meet stiff competition.

The data shown in Table 4 are of interest both to medical faculties and to those primarily responsible for training programs. We must satisfy both requirements with the limited supply of available residents. Since many

of the foreign nationals in the programs at present will return to their countries after completing the residency, we must primarily depend on our native graduates to meet the needs of medical education as well as patient care. I believe the data in this chart will indicate to our friends who are practicing in non-affiliated centers that they are receiving their fair share of young men interested in obstetrics and gynecology, but that the number of graduates selecting this discipline is relatively small.

Within another six months gynecology, if not obstetrics, may meet another challenge from the implementation of federal medical assistance to the aged. Voluntary third-party payment plans have already presented a threat to training programs in surgery and allied specialties. The internist and pediatrician have rarely appreciated this problem, since their patients can be utilized effectively by a number of individuals in training. This is not the case in surgery where the young resident needs to actually perform procedures in order to become competent in his field. It is not unreasonable to expect that within the next five or ten years all hospital patients will be covered by some form of third party payment, and the ward or staff patient who has been the cornerstone of training in surgery and allied specialties will no longer be available for training purposes.

It is essential that we have the understanding and cooperation of the entire medical profession if we are to solve these problems. The present policy of some Blue Shield plans, established by the profession, will not permit payment for services rendered by the resident even though the patient is admitted to the ward or staff service. Several mechanisms may be worked out whereby the resident in training would become the sole re-

recipient of the benefits of any fee for service rendered under these circumstances, but this matter will require the sympathetic understanding and approval of the medical policy boards of these plans.

The federal fee for professional service poses an even greater threat to residency training. If the present policy, which requires the statement, "I am not an intern, a resident, or otherwise in training status," is extended to other federal programs, it will exclude another group of patients from the resident's service. Some of these difficulties can be avoided by giving the chief resident a staff appointment as obstetrician and gynecologist. Unfortunately it will not completely solve the problem, and it will be necessary to gain acceptance of a new definition for "training status."

Finally we need to say something about the average stipend received by the resident in obstetrics and gynecology. Salaries in the affiliated programs are frequently unrealistic and do not take into account the valuable contribution he makes to undergraduate education. In addition he is in an unfavorable position with regard to residents in other disciplines in the same hospital, who are supported by a federal program paying two or three times more than the salary he receives. One of the reasons for continuing this

system is our reluctance to change policies which have been in operation for 20 or 30 years. The present resident is usually married, has one or more children, and finds himself in greater financial stress than the unmarried resident of the past who received a monthly salary of \$50 to \$100.

Some of the inequities in the affiliated programs can be corrected if the medical schools will recognize the importance of the resident as a teacher and will assume some of the responsibility for his salary. This problem is less serious in the nonaffiliated programs where residents in general receive a more realistic salary.

Conclusion

Some aspects of residency training in obstetrics and gynecology require improvement if the discipline is to play its proper role in patient care, teaching and research. I have tried to discuss these problems realistically but not pessimistically since they must be recognized and understood before they can be solved.

I would like to close with a quotation from the late General Harbord: "The roads you travel so briskly lead out of dim antiquity, and you study the past chiefly because of its bearing on the living present and its promise for the future."

It is a reproach to learning that any of her votaries, to relieve the mind after study, should betake themselves to the use of strong liquors. This indeed is a remedy; but it is a desperate one, and always proves destructive. Would such persons, when their spirits are low, get on horseback and ride ten or a dozen miles, they would find it a more effectual remedy, than any cordial medicine or strong liquors.—William Buchan: *Domestic Medicine, or a Treatise on the Prevention and Cure of Diseases by Regimen and Simple Medicine*, etc. Philadelphia, Richard Folwell, 1799, p. 59.

Keeping Current

JOHN M. PARKS, M.D.

WASHINGTON, D. C.

Among modern men of medicine no one better embodies the concept of keeping current than Dr. Robert A. Ross. Throughout his 43 years as a physician he has frequently been ahead—never behind—and always current with the society and the science of which he has been a part. A survey of his many publications shows that in the thirties he had an interest in the Keilland forceps, occiput posterior eclampsia, lipiodal roentgenography, marriage counselling, ovarian function, and—I especially like the title of this paper—"Granny Grandiosity."

While at Duke University in the forties, he made fundamental contributions to our knowledge of endocrinology, sex endocrine therapy, genital infections and malignancies, and toxemia of pregnancy.

In 1952 he returned to his alma mater, the University of North Carolina, where he developed a strong new Department of Obstetrics and Gynecology. As evidence of the timeliness of his thinking, the title of his three most recent papers are "Phagocytes in Host Parasite Interactions," "Intrauterine Contraceptives," and "The Care of the Elderly Female." Who could be more current!

But this quality of keeping up with scientific progress, of perfecting and projecting a characteristic personal and professional identity, requires the ability to read voluminously, to listen intently, to see clearly, to think independently, and to speak explicitly. Robert A. Ross has these multiple abilities in abundance. He is a scholarly scientist, a true teacher, an excellent writer, and a superb speaker. He has a contagious cheerfulness coupled with intense loyalties. In addition to the five natural senses we are born with, "Daddy" Ross possesses a sixth sense second to none—a phenomenal sense of humor. His

humor adds to the learning of those about him and reassures those who depend upon him for the maintenance of their health.

As teachers of medicine, learning and health are our two major responsibilities. Health is man's most important possession. There are ample reasons for the public to be interested in and the profession concerned about keeping current with medical progress. Health has been categorized into ages and diseases, specialties and procedures, all of which are on public display. The pressures of public opinion are having an increasing influence on the activities of the medical profession. Madison Avenue promoters have placed "tappers" in our refrigerators and "tigers" in our tanks. Equally capable promoters and writers, with and without medical degrees, keep a constant flow of scientific information about health before the American people. Nearly every daily newspaper contains a health column. Magazines, radio, and television maintain an intense public interest in medicine. The pulse of astronauts and the medical histories of public figures have personal meaning to a large segment of the population.

As physicians we may feel strongly about what should or should not be publicized, but public knowledge about medical care can be helpful. In our own specialty we recall the pressure put upon many of us to accept the advantages of routine Papanicolaou smears. This procedure has paid large dividends in health to thousands of women. More recently, Dr. Albert Sabin has demonstrated, not only great ability as a scientist, but unflinching courage and masterful statesmanship in the promotion of health measures which have virtually eliminated poliomyelitis in our country. The strong tides of public opinion are forcing changes in laws governing birth control. Population profiles will not be modified without public knowledge and acceptance of methods of birth control.

*Dean of the School of Medicine, George Washington University, Washington, D. C.

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Physicians have ethical qualms about publicity; it often frightens them. They fear being quoted out of context and being criticized by their colleagues for self-advertisement. From the journalist's point of view this is absurd. Nothing that is news can be kept out of print; anything that is not news cannot be gotten in. But we are not very comfortable when we are told, especially by laymen, about our country's large number of mental defectives, about the rising incidence of venereal diseases, about our neonatal mortality, or about the appalling loss of lives from heart disease, cancer, and stroke.

As physicians we subconsciously feel responsible for everyone's health and readily rise to the defense of our profession. But defense is not the answer. We need to cooperate with the fast-moving forces of modern communication, for they are having an increasing influence on our profession. It is essential that members of medical societies and faculties of medical schools cooperate closely with the press to bring to public attention features of medical education, research, and practice that will be of greatest benefit to humanity. One of the frequently cited problems of our eruptive scientific age is the gap between the discovery of useful knowledge and its full application to all the people. The public has presented strong demands to the 89th Congress that social advances be made immediately available to everyone. Senator Hill has said, "Our reach exceeds our grasp." A discussion of recent health legislation is not germane to this program except to say that with greater public interest in health affairs, it will be more important than ever that physicians keep current. They must actively share in the social as well as the professional responsibilities of their communities.

Health has become one of our largest businesses. Total expenditures in the United States for health and medical services continue to increase. They now absorb more than 5% of the gross national product. Governmental expenditures at all levels have been rising, but for the past ten years the ratio of governmental expenditures has remained at about 24%. This level will undoubtedly

change when Medicare and the health features of the poverty program go into full effect.

Multiple interests in health have produced volumes of new scientific, social, and economic information that directly influence the lives of physicians. Selectivity in what we read, listen to, see and evaluate is becoming increasingly important. No one can possibly read all that is written in his own field, let alone that of all of medicine. Useful articles are widely distributed in many journals. Condensations, surveys, year books, reviews, and medical digests represent convenient forms of selectivity for the busy scientist-practitioner. But it is difficult at times to separate scientific articles from advertisements, and in condensations an entire concept may be distorted by lifting material out of context. The automated reproduction of printed materials has improved communication immensely, and computers are now capable of selecting and sorting useful information infinitely faster than any man's mind. How may we best use scientific and educational processes to keep current and still have time to enjoy our lives as physicians?

It has been estimated that 9% of our waking hours is spent in writing, 16% in speaking, and 45% in listening.¹ We tend to teach by reading, writing and speaking, but the largest segment of our learning time is devoted to listening. The greatest art in medical practice is the ability to give undivided attention to the individual patient. Impatient listening on the part of the physician is quickly sensed by the patient and others concerned.

Reading and listening are intake procedures, whereas writing, speaking, and operating are output procedures. Each is dependent upon the others, and since listening is the most frequently used process in learning, there should be ways to improve our listening habits.

The brain is capable of receiving words four times faster than the average person speaks. Communication speeds for speaking have been estimated at 150 words per minute. It is easy for each of us to list our poor listening habits; perhaps the worst habit is

mind-wandering. Professor Ralph Nichols of the University of Minnesota sees an advantage in being able to listen faster than the speaker can talk: He says that it gives time to "think between the lines."² He believes that by thinking we can learn more than we actually hear, and suggests the following procedures for making listening more profitable:

1. Anticipate points and then compare ideas
2. Sift the facts and weigh the evidence
3. Make mental summaries of thoughts expressed versus your own opinions.

These procedures keep the mind centered on the subject.

The style and substance of speaking influence the ability to listen. Sitting next to Dr. William Mengert at a medical meeting, I noticed that in the course of a particular speech he repeatedly punched a stop watch. When the meeting was over I asked for an explanation. He said, "I was recording the 'as you knows' and the 'ahs and uhs.' They took up 15 minutes of the speaker's time."

A part of our new mechanical age will consist of edited scientific talks where filler words are removed, the essence of the presentation is retained, and if indicated the voice is speeded up. The condensed taped talk will be fitted into a convenient small canister for home, office, or auto use. The Ford Motor Company has introduced a built-in high fidelity speaker into which a small canister containing taped recordings can be placed. There is no reason why this equipment cannot be used for taped lectures as well as for music.

When a speaker uses slides or motion pictures he communicates more effectively. Seeing and hearing demand more attention than listening and writing. When a slide is projected on a screen, we "read" the picture while listening to the description. Medical educators can profitably use some of the techniques of the television and motion picture industry.

The new Fairchild Mark IV projector with self-contained screen makes it possible to use natural color 8-mm film, loop-loaded in plastic canisters for easy daylight showing in a machine slightly larger than an x-ray viewing box. Short, single-concept films lasting

5, 10, or 15 minutes can increase immensely the effectiveness of time spent in learning. These machines, built for self-operation, can be used in medical libraries, offices, or clinics. The entire course of a disease can be demonstrated within 5 to 10 minutes. For example, all the significant features of leprosy have been recorded on an 8-minute film representing a digest of a much longer one.

At the George Washington University Air-lie Center we have produced for the Communicable Disease Center of the Public Health Service 17 short films on venereal disease, each of which contains material that would take hours to read in the library or see in a clinic. Condensed films for easy self-teaching will become important learning tools for all medical scholars. It is easy, too, to visualize the information that such films could provide patients waiting in physicians' offices. Procedures such as self-examination of the breasts, self-administration of insulin, and prescribed exercises that physicians, nurses, and technicians spend time in teaching could be learned from concise films made readily available for patient review.

If I have dwelled rather heavily on the mechanics of learning, I did so intentionally for we are living in a mechanical age. Our minds, our emotions, our practices, our ways of life are bound to be profoundly influenced by a rapidly advancing scientific society. To keep current today and tomorrow we must find simplicity and usefulness in our methods of communication.

In the words of Gilett Burgess:

Life is too short for regrets.

Living is the pursuit of fun.

If you want money you specialize. But

If you want fun you create new things.

As new things are needed in medicine they will be developed through forward thinking. As physicians we all have an opportunity to promote health and well-being in our patients, but few of us have the ability to project into our professional lives the scholarly optimism that is so characteristic of Dr. Robert A. Ross.

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NOVEMBER, 1966

ROBERT ALEXANDER ROSS, M.D.

That "Daddy Ross" is to be the next president of the Medical Society of the State of North Carolina is appropriate recognition of a man who has devoted his life to advancing the standards of medical care and the status of physicians in his native state; a warm and friendly man who says the right thing at the right time; a man with an inherent sense of humor and a deep understanding of those about him—their problems and ambitions, their accomplishments and frustrations,

their abilities and limitations. On many occasions his remarks have given rise to general amusement and even hilarity for audiences of physicians who realized somewhat later that they had been evaluated and found lacking; that they had been called to task and given a basis for improving the care of their patients—but with such empathy that his hearers could feel only gratitude and determination to meet the challenge. It can be said with certainty that on such occasions his message was always clear and he received the undivided attention of his audience.

Daddy Ross's efforts in the education of those about him have been continuous, and his relationships with young and old, in all branches of medicine, have made him a respected and beloved leader. All know that they can depend upon receiving a helping hand in time of need and that his friendship never wavers.

His concern with the medical problems of women and investigations of major trends and influences in the health field led to numerous publications in regional and national medical journals. These writings dealt with the diagnosis and treatment of toxemia of pregnancy, pelvic cancer, maternal and perinatal mortality and morbidity, and many other topics.

National recognition and a position of leadership in obstetrics and gynecology properly came to Daddy Ross early in his career. He was the first North Carolinian to receive the honor of membership in the American Association of Obstetricians and Gynecologists and the American Gynecological Society. He was also a charter member of the American Board of Obstetrics and Gynecology, a member of the American College of Obstetricians and Gynecologists, the South Atlantic Association of Obstetricians and Gynecologists, and other organizations, holding important offices and appointments in all of them.

The physicians of North Carolina have honored Daddy Ross in making him their President. In so doing they have honored themselves and the Medical Society of the State of North Carolina.

FRANK R. LOCK, M.D.

DISCRIMINATION IN THE AUTOPSY ROOM

The records of the autopsy service of the North Carolina Baptist Hospital indicate that 60% of those on its rolls are males. Similar observations apply to most general hospitals. The reason for the male preponderance cannot be definitely stated, and any opinion voiced is bound to lead to charges of misogyny, cynicism, curmudgeonliness, or what not—all of which may be justified. Despite the risk involved, a few opinions can be ventured.

Perhaps the likeliest explanation, in keeping with our editorial of a few months ago, "The Practical Female," is that women are less sentimental than men. When a husband dies, his wife, dearly attached to him though she may have been, feels that the only useful purpose his body may now serve is to educate physicians and other medical people. She therefore permits an autopsy. When a wife dies, on the other hand, the husband cannot be that objective and is less likely to agree.

Another possibility is that children, with greater sentimental attachment to mother in most cases, prevail upon father not to permit an autopsy, but do not go to similar lengths when father dies. Such an attitude is aided by the matriarchal trends which Philip Wylie groups under the label "momism" (and supported by the fact that more money is spent for Mother's Day than Father's Day).

More involved is the supposition that more men than women are subject to autopsy because the wife usually outlives the husband, and a spouse is more likely to give permission for an autopsy than a child. The truth of this last assumption cannot be affirmed without study, and such a study has not come to our attention.

On the more frivolous side one might propose that the ladies would like documentation on the cause of death and the events which led to it, the better to argue with physicians and insurance companies about the case. Since the ladies have to take more care

for their economic welfare after the death of their husbands, this too is understandable.

Perhaps one day soon the subject of this inequality in death will lead to a doctoral dissertation. If we get wind of such an opus, we will pass the word along (though not necessarily believing in it).

* * *

VENEREAL DISEASE IN NORTH CAROLINA

Since North Carolina is among the front runners of the fifty states in prevalence of venereal disease, it seemed in order that our State Health Department be asked to keep us informed about progress in control of these infectious diseases here in our state. The first of a monthly series of short communications from them appears in this issue. Our membership is no doubt as much interested as anyone in putting our venereal disease ranking down where the per capita income of the state presently resides, and vice versa, and observations and statistics appearing in the Health Department's column may aid in the battle.

Why should North Carolina have so much venereal disease? Looking at the national rankings, there does seem to be some correlation between low per capita income, a large nonwhite population, and venereal disease. In these respects we fit the pattern. Is it because the physicians of the state are more zealous than others in reporting cases? Not likely, although this supposition cannot be proved one way or the other. With so much attention given recently to the sharp rise in the birth rate in New York City hospitals nine months following the power failure last year, one wonders if we are part of a television deprivation syndrome which leads to increased VD as a by-product. To judge from the prevalence of TV antennas throughout the state without regard to the elegance of the dwelling, this seems unlikely also. Whatever the reason, history has proved that information about VD has an important beneficial effect on its control, and we are glad to lend a hand.

The President's Page

THE DANCE ON THE KNIFE EDGE

At Asheville in May of this year, I said: "Tomorrow brings us to the probability of a dance on the knife edge of means and averages; the possibility of regimentation and control; the possibility of dilution of incentive. . . ." Since then I have not had cause to change my mind.

Your president has an opportunity which is not available to all members of this Society. The stream of communication that flows in from divers sources is frankly confusing. There was a time when the presidency of a state medical society was totally state-encompassed, as far as his function was concerned. Today this concept is entirely changed. Every day we deal with matters that are on a regional—nay, national—basis. Monthly, and sometimes weekly, we attend meetings that involve the practice of medicine on a national level. The things we hear, the things we are told, the implications we get from presentations by public officials and others both in and out of medicine, involving the entire gamut of health care, can no longer be confined within a single geopolitical area such as a state. Events that affect Alaska and Florida affect North Carolina, and conversely, things that affect North Carolina affect the entire world. We are no longer insular, regardless of how secure a state or a county may feel behind its fences, confident that it can depend for existence upon its own internal economy.

Now, let us return to the dance on the knife edge. This affects you and it affects me. I may have a bit more information. If I do, it is proper that I try, with the means available, to disseminate that information. What you do with it is your business. I will make no recommendations for the reason that I am speaking to a group of highly educated and intelligent people. To use the argot of the current younger generation, you, if anyone, should be "hep."

At the moment we will discuss a few of the things that affect us as far as the practice of medicine is concerned—the dance on the knife edge.

It is not here at the moment. It is here in the books. It is here in the plans. This gives me the privilege of talking a little about some of the things I have learned. Admittedly, some of what I say is interpretative. Disagree if you will, but at least take a look at what is being said.

Computer-based Medical Data Systems

Some new terms have come into the lexicon of hospitals involving the automation of hospital records. The first is Hospital Administrative Services (HAS). The second is Professional Activity Study (PAS). The third is Medical Audit Program (MAP).

The Hospital Administrative Services program interests doctors, of course, but perhaps less directly than the other two. The Professional Activity Study actually leads into what is called the Medical Audit Program. It has been said that PAS is the basic component of MAP.

What happens here is that on a form used in PAS, medical information with reference to an individual case is entered by the record librarian of a given hospital and forwarded to a computer center for further handling. The pencil-marked PAS form is then transferred to a card by a key punch operator and subsequently verified to reveal any errors in punching or apparent inconsistencies in the markings on the form itself. From the punch cards the information is transferred to magnetic tape by the use of a computer. The computer is further utilized to categorize the data received as needed for the studies involved. In some instances the two programs have been combined to the extent that the data required for PAS and MAP can be filled in by the local medical librarian on a single form.

The Duke Foundation has made available the data-gathering function of HAS and PAS to hospitals in North and South Carolina that receive support from the Duke Endowment and subscribe to the programs. Since many North Carolina hospitals fall into this cate-

gory, a large number of physicians will be affected.

A detailed discussion of PAS-MAP is unfeasible here, but I will touch on a few of the more significant aspects. One of the primary functions is to determine the pattern of current medical practice. Computer data-processing will make comparisons possible not only between hospitals but between physicians in the same hospital. It will be very easy to do a statistical audit on the medical competence of an individual physician. (Note carefully the use of the word "statistical.") Comparisons of such variables as recovery time, mortality rates, as well as hospital utilization can be made between the small hospital and the teaching center, or between one part of the state or country and another.

The development of statistical profiles of hospitals and physicians has been the practice of various organizations for some time. As the result of studies conducted both inside and outside the insurance field, utilization norms by diagnoses have already been established for a number of diseases. Patterns have been set for some of the more common admission and discharge diagnoses—for example, average hospital stays for arteriosclerotic heart disease, diabetes, hernia, gallstones, dental problems, and so forth. Often these data are utilized to compare local, regional, and statewide patterns of care.

It is recognized that limitations of the computer are based on input and programming. The output depends on what the computer is asked to develop as a result of the input. All that is required to develop computer-based profiles for individual hospitals and physicians is the data on the hospital charts.

For example, the length of stay for patients undergoing cholecystectomy might be under study. The data utilized here would be contained in the records of patients categorized according to a specific code—in this instance, 584 or 585 (International Classification of Diseases, Adapted). From this information the total average stay, preoperative stay, and postoperative stay; the total number of patients undergoing the procedure in the various hospitals, and the median age of

the patients could be determined. The data could be broken down further to apply to individual physicians. And all this would be available for studies by hospitals.

What do we mean by the hospital? It could mean the medical staff; it could mean the board of trustees; it could mean an outside agency surveying the hospital. We are told that a great many restrictions are placed around the data submitted on a PAS-MAP study. We are not told how long these restrictions will apply.

There is always a fear that statistical studies such as these do not reflect the actual difficulties encountered, as there is no provision for an individual case. Truly one dances on the knife edge of means and averages.

Do you keep your acute coronary patient in the hospital too long? Unfortunately the computer has nothing to say about the patients who do poorly after being discharged too soon, possibly because the physician was coerced, shall we say, by the specter of means and averages. It does not reflect the number of office visits a postoperative patient might have to make because he had not remained in the hospital as long as the physician judged proper.

It is paradoxical that while the quality of medical care is emphasized so much today, quantity, or numbers, appear to be the ruling factor. *Get them in, get them out!*

This is not intended as a condemnation of the PAS-MAP studies. I say only that we should be aware of what they do mean. They may mean a great deal for us. It is possible that they will prove a wonderful method of individual assay—that is, an opportunity for the physician to judge his performance in the care of patients with that of other physicians. What are his results in treating a given disease as compared with his associates'? Do his diabetes cases take longer to control? Are his operations associated with a greater morbidity?

If the answer is yes and he discovers it for himself, it behooves him to return to the books, to the literature; to attend some seminars and postgraduate courses. Perhaps he has become stagnated. Possibly his volume of

practice is so great that he cannot give individual patients the necessary attention.

Much good can come from these programs. The problem is the possibility of a stranglehold—a dance on the edge of knife edge of means and averages.

What is the meaning of *mean, average, median, prevailing, range, usual, customary*? These factors in the Dance will be explored in Part Two of this discussion.

FRANK W. JONES, M.D.

Committees & Organizations

NORTH CAROLINA STATE BOARD OF HEALTH

VENEREAL DISEASE CONTROL SECTION DIVISION OF EPIDEMIOLOGY

STEMMING THE TIDE OF SYPHILIS

The 1960's so far have witnessed a resurgence in the number of cases of infectious syphilis reported in North Carolina.

Reports received by the Division of Epidemiology of the North Carolina State Board of Health in 1960 revealed 466 cases of primary and secondary syphilis, 60% of which occurred within the age range of 15 through 24 years. In 1965 the number reached 1138, an increase of about 250%, with 38% of the cases occurring at age 15 through 24 years. The total number of cases of gonorrhea reported annually during the first half of the decade has also increased. Last year, 11,857 cases were reported, with 66% occurring within the ages of 15 through 24 years.

Venereal diseases accounted for 77% of all communicable diseases reported in North Carolina during 1965, with gonorrhea ranking first and syphilis second.

What can be said about the problem of syphilis in North Carolina and, perhaps more importantly, what can be done about it? It is no honor to be sixth among the top-ranking states in the number of cases of syphilis reported.

The first essential is to be aware of the problem, if we are not already aware of it. The second essential is to realize that merely treating the cases that come to light is not of itself sufficient to reduce the incidence and control the spread of the disease. Case-finding by routine examinations is extremely

helpful, but as physicians we can play a highly significant role by initiating investigation and follow-up of contacts. In cases of primary syphilis, this investigation should go back over the preceding three months, and of secondary syphilis, the preceding six months. With this systematic approach we can expect to find new cases and have an opportunity to institute prophylactic treatment among those who may be incubating the disease.

Time is of the essence, and the epidemiologic measures cannot wait if the disease is to be prevented from spreading. Toward this end, a force of thoroughly trained field epidemiologists is maintained to serve all areas of this state, and indeed all the other states. These trained specialists are on immediate call to assist physicians in the somewhat time-consuming task of interviewing known patients in order to identify, in strict confidence, contacts who may have contracted the disease, and to bring them to examination by their own physicians or local clinics. Prophylactic measures can then be seriously considered and, if decided upon, can be expected to abort a substantial number of cases.

If this procedure is assiduously applied in every case, we may be able to look forward to a day when syphilis is no longer a significant cause of disability in our population. If it is ignored, syphilis may (barring a breakthrough in epidemiology) continue to climb, and history may regard us with some incredulity, since we have the cure for the disease and the means of eradicating it at our fingertips.

Blue Shield Scores Membership Gains

Blue Shield membership and benefit payments both reached record highs during 1965, while operating expense fell to a new low, according to the National Association of Blue Shield Plans.

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COMING MEETINGS

North Carolina District, American College of Physicians—North Carolina Society of Internal Medicine, Joint Meeting—Charlotte Memorial Hospital, Charlotte, December 9-10.

1967 National Rural Health Conference—Charlotte, March 10-11.

Duke Pediatric Seminar—Duke University Medical Center, Durham, March 14-16.

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John Asbury McGee, Jr., M.D., 2811 C Middleboro Court, Aberdeen Proving Grounds, Md.

John Terrence Hayes, M.D., Or, Bowman Gray School of Medicine, Winston-Salem

John Wing Charlton Fox, M.D., 743 Austin Lane, Winston-Salem

Elisabeth June Fox, M.D., Anes, 743 Austin Lane, Winston-Salem

Richard Lewis Taylor, M.D., GP, 419 Linden Avenue, Raleigh

Rupert Spencer Eaves, M.D., Oph, 224 New Hope Road, Gastonia

NEWS NOTES FROM THE DUKE UNIVERSITY MEDICAL CENTER

A new book on orthopedic surgery has been dedicated to the Virginia Flowers Baker Professorship of Orthopedic Surgery at Duke University School of Medicine.

Called "Current Practice in Orthopedic Surgery," it is written by an alumnus of Duke's division of orthopedic surgery, Dr. John P. Adams, professor of orthopedic surgery and chairman of the section of orthopedic surgery at George Washington University School of Medicine.

The Virginia Flowers Baker Professorship honors the memory of Mrs. Virginia Flowers Baker, who died April 14. Mrs. Baker was the wife of Dr. Lenox D. Baker, professor of orthopedic surgery and chairman of the division at Duke.

Dr. Baker and five other members of Duke's orthopedic division were contributors to the book, third volume in a series.

Duke University Medical Center has established a new division—audiovisual education—and appointed Sam A. Agnello as its director.

The new division encompasses three facilities—medical art and medical photography, once a single unit, and medical television.

Agnello, who has been coordinator of medical television since 1964, will continue to function in that capacity as well as direct the overall operation.

Because of an increase in the workload, medical art and medical photography, have been separated into single facilities. Elon Clark, professor of medical art and illustration, will be coordinator of medical art.

Medical photography will be headed by a newcomer to the Duke staff, Wayne C. Williams, who takes over Nov. 1. Williams is director of the Department of Medical Illustration at the University of Kentucky Medical Center.

An A.B. graduate of Duke, Angello is secretary-treasurer of the Council on Medical Television, Inc., a member of the National Biological Photographic Association, and a former vice-chairman of the Southeastern chapter of that group. He also is a member of the National Association of Education Broadcasters and a member of the audiovisual instruction department of the National Education Association.

The new division will work closely with all educational programs at Duke Medical Center, assist the medical library in the circulation of audiovisual materials, help existing programs, assist and provide services for research efforts, and sponsor graduate and postgraduate seminars in audiovisual services.

* * *

A Duke University immunologist was among a group of nationally known experts participating in an inquiry into public policy on biomedical knowledge in Oklahoma City Oct. 24-27.

He is Dr. D. Bernard Amos, professor and chairman of the division of immunology at Duke. Dr. Amos has been primarily responsible for the development of a reliable way to determine the best candidate to donate a kidney for transplantation.

The forum was held to discuss problems raised by President Johnson in his June 15 statement concerning the application of biomedical knowledge, "... for reducing deaths and disabilities and for extending research in that direction. . . ."

* * *

The Department of Obstetrics and Gynecology, Duke University Medical Center, announces the establishment of the Southeastern Regional Center for Trophoblastic Neoplasms. This Center is sponsored by a Health Service Project Grant Award from the Department of Health, Education and Welfare, Division of Chronic Diseases.

This project in Cancer Control is established for the purpose of providing urinary gonadotropin assays and consultative assistance to physicians to aid in evaluation of patients who have or are suspected of having abnormalities in trophoblastic tissue growth.

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* * *

Two title changes and two appointments at Duke University Medical Center were announced recently by Dr. R. Taylor Cole, university provost.

Affected by the title changes are Dr. Kenneth L. Pickrell, professor of plastic surgery, who has been named professor and chief of the Division of Plastic and Maxillofacial Surgery, and Dr. Rubin Bressler, associate director of the Clinical Research Unit and now director of the Division of Clinical Pharmacology.

Dr. David R. Rowlands, formerly an assistant professor with The Rockefeller University, has been appointed associate professor of pathology. Dr. David L. Young, formerly a U. S. Public Health Service fellow at Yale University was named an assistant professor of medicine.

Dr. Pickrell has been at Duke since 1944 and has been both secretary and president of the American Society of Plastic and Reconstructive Surgeons.

Dr. Bressler came to Duke in 1959 as a senior assistant resident in medicine. He recently was promoted from associate professor of medicine to professor of medicine and professor of pharmacology.

Dr. Rowlands received his M.D. degree from the Medical School of the University of Pennsylvania. Before joining the faculty of The Rockefeller University in 1964 he was an assistant professor at the University of Colorado.

Dr. Young has had two other research fellowships in addition to the one at Yale. They were awarded by the Dallas Heart Association and the National Science Foundation for postdoctoral training at the Max Planck Institute, Munich, Germany. He received his M.D. degree from Southwestern Medical School of the University of Texas in 1956.

* * *

A Duke University scientist has accepted an appointment by the National Academy of Sciences Research Council to join a group of experts in reviewing the claims for effectiveness of drugs marketed in the United States between 1938 and 1962.

He is Dr. J. Graham Smith, professor of dermatology at Duke Medical Center. Dr. Smith will be a member of a panel studying drugs used in dermatology. The panel will review various categories of information that will be assembled about each of the drugs.

The council has undertaken to carry out this work on behalf of the Federal Food and Drug Administration (FDA). The panel's final report will classify the drugs in question as effective, probably effective, possibly effective or ineffective.

* * *

Dr. Philip R. Allison, Nuffield Professor of Surgery at the University of Oxford, England, delivered the fourth annual Deryl Hart Lecture in the new amphitheater of Duke University Medical Center on Oct. 26. His topic was "Surgery, Thrombosis, and Clotting."

Presentation of the lecture coincided with the in-

auguration of a university-wide function called "The Dean's Hour."

The Dean's Hour will be sponsored by Dean W. G. Anlyan of the School of Medicine with the cooperation of the entire medical school faculty. Its purpose is to offer students the opportunity of hearing discussions on major themes of interest by distinguished lecturers, both visiting and local.

* * *

Dr. Max Woodbury, professor of bio-mathematics at Duke University Medical Center, has been appointed an associate in the University Seminar on Mathematical Methods in the Social Sciences at Columbia University.

Dr. Woodbury, a nationally known mathematician and computer expert, joined the Duke staff in January, coming here from New York University where he had been professor of experimental neurology and head of the school's communication science section since 1962.

Recently he was appointed to a science advisory committee for New York City. He has been a member of the Columbia seminar faculty since 1951 and has presented several papers at seminar sessions.

NEWS NOTES FROM THE BOWMAN GRAY SCHOOL OF MEDICINE OF WAKE FOREST COLLEGE

Work is under way on the renovation of hospital space for a new general clinical research center which is being established at the Bowman Gray School of Medicine through an initial grant of \$282,920 from the National Institutes of Health.

A six-bed unit will serve the program temporarily. This facility will be replaced in three years by a new 12-bed unit, included in the medical center's \$28-million expansion program.

Support of the clinical research center has been approved for a five-year period by the Division of Research Facilities and Resources of NIH, with the total amount of the award exceeding \$1,000,000. The funds will make it possible to develop a research unit in which the skills of various disciplines can be concentrated upon a relatively small number of patients with a wide range of diseases and disabilities.

The establishment of the new unit will bring to 91 the number of general clinical research centers in the nation.

Dr. Richard L. Burt, professor of obstetrics and gynecology, was named director of the Bowman Gray clinical research center which will be available to all members of the medical faculty for the investigation and intensive observation of patients with special problems.

* * *

Dr. Robert L. Tuttle, associate dean, was elected vice chairman of the Southern Association of Medical Colleges at a recent meeting of the organization in Richmond, Va. The association membership includes representatives of 28 medical schools in the southern region.

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Dr. Irving S. Wright, president of the American College of Physicians, was the first lecturer in a year-long program commemorating the 25th anniversary of the Bowman Gray School of Medicine.

Appearing as a Reynolds Foundation Distinguished Lecturer, Dr. Wright spoke Sept. 15 on "The Present Status of Long-Term Anticoagulant Therapy."

The medical school, established in 1902 in Wake County as the two-year Wake Forest College School of Medicine, was moved to Winston-Salem in 1941 as the Bowman Gray School of Medicine and its curriculum was expanded to a full four-year program.

* * *

Two members of the Bowman Gray faculty presented papers at the International Symposium on Atherosclerosis and Reticuloendothelial System Sept. 8-10 in Como, Italy. Dr. Quentin N. Myrvik, professor and chairman of the Department of Microbiology, spoke on "Effect of Bacillus Calmette Guerin on Metabolism of Alveolar Macrophages." Mrs. Eva S. Leake, research assistant professor of microbiology, presented a paper on "The Persistence of Intact Mycobacterium Smegmatis in Normal Alveolar Macrophages as a Consequence of Delayed Development of an Effective Digestive Vacuole."

* * *

Dr. Howard H. Bradshaw, professor and chairman of the Department of Surgery, participated in an educational course for South American physicians Sept.

26-29 in New York City. He presented a paper on "Diagnosis and Treatment of Parathyroid Tumors" and chaired a session on "Tumors of the Endocrine Organs." The course was sponsored by the American Cancer Society.

* * *

Three members of the Department of Biochemistry participated in the 152nd meeting of the American Chemical Society Sept. 11-16 in New York City. Presenting papers were Dr. Robert W. Cowgill, associate professor, "Solvent and Structural Effects on Peptide Fluorescence;" Dr. Frank H. Hulcher, assistant professor, "Fatty Acid Composition of Cholesterol Esters in Bovine Myelin;" and Dr. Cornelius F. Strittmatter, professor and chairman of the department, "Development and Component of Avian Phenylalanine-Hydroxylating System."

* * *

Dr. John W. C. Fox, assistant professor of anesthesiology, was one of 20 panelists at the first International Symposium on Neuroleptanalgesia Sept. 29-30 in Philadelphia, Pa. Participants were selected from institutions in the United States, Canada and Europe.

* * *

Dr. H. O. Goodman, associate professor of medical genetics, presented the 21st in a series of Geigy Lectures at Western Carolina Center in Morganton. He spoke on "Genetic Factors in Mental Retardation."

* * *

Dr. Frank R. Lock, professor and chairman of the Department of Obstetrics and Gynecology, delivered the presidential address at the 77th annual meeting of the American Association of Obstetricians and Gynecologists Sept. 8-10 in Hot Springs, Va. He spoke on "Preparing the Doctor to be a Doctor: The Importance of Including Material from the Field of Behavioral Science in the Medical Curriculum" before turning his gavel over to Dr. Harold Gainey of Kansas City, Mo., incoming president of the association.

* * *

Dr. I. Meschan, professor and chairman of the Department of Radiology, presented a paper on "Differential Renal 131-I Renografin Clearance in Various Clinical Conditions" at a symposium on Dynamic Function Studies and Organ Scanning Sept. 10 in Danbury, Conn.

* * *

An exhibit, prepared at the Bowman Gray School of Medicine, on "The Quantitation of Differential Renal Clearance Without Ureteral Catheterization" was presented by Dr. C. Douglas Maynard, instructor in radiology, and F. C. Watts, research associate in radiology, at the annual meeting of the American Roentgen Ray Society in San Francisco, Calif.

* * *

Dr. Emery C. Miller Jr., associate professor of medicine, was a member of the faculty for the 14th annual Diabetes Seminar of the Florida Diabetes Association Sept. 29-30 in Miami Beach, Fla. He lectured on "Recent Advances in Diabetic Management;" "Oral Hypoglycemic Therapy;" and "Diabetic Retinopathy."

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ASHEVILLE, North Carolina

NEWS NOTES FROM THE
UNIVERSITY OF NORTH CAROLINA
SCHOOL OF MEDICINE

Dr. Walter Hollander, Jr., director of the Clinical Research Unit at N. C. Memorial Hospital in Chapel Hill since it was established in 1960, has been appointed an assistant to the dean of the UNC School of Medicine.

Dr. W. B. Blythe succeeds Dr. Hollander as director of the Clinical Research Unit.

Dr. Hollander is an associate professor of medicine and has been on the medical faculty since 1956.

* * *

Clues as to why some heavy drinkers develop fat livers were introduced in New York City at the national meeting of the American Chemical Society by a UNC biochemist.

Dr. Edward Majchrowicz of the departments of biochemistry and psychiatry said that chronic drinking can cause the liver to lose its normal metabolic function.

Researchers have shown previously that alcohol stimulates the release of fats from storage depots throughout the body. These excessive fats pour into the liver.

Dr. Majchrowicz now finds that an inhibitory effect compounds the problem of the overload of fats. His experiments show that alcohol slows down fatty acid oxidation in the liver.

* * *

The most recent findings about hormones—the body's "chemical messengers"—are being reported at a series of weekly meetings which began on Sept. 24 at the UNC School of Medicine.

The series continues through Nov. 19.

Nine outstanding medical researchers are scheduled for the 1966 Medical Sciences Lecture Series sponsored by the UNC medical school and Medical Education for National Defense.

All meetings are held at 11 a.m. on Saturdays in the clinic auditorium of N. C. Memorial Hospital in Chapel Hill. Closed-circuit television will accommodate a run-over attendance in Room 324 of the medical school.

Following each hour lecture, anyone interested has an open invitation to an informal Dutch luncheon in the hospital's private dining room for further discussion with the speakers.

* * *

The Class of 1970, numbering 70 students, already has unique distinctions to its credit.

It is the first class at the UNC School of Medicine to have Morehead Medical Fellows in its midst. William J. Busby of Salisbury, John R. Leonard, III of Lexington and George M. Oliver, Jr., of Cary were selected early this year to receive fellowships valued at \$10,000 each plus tuition and fees over four years.

The class has more women students than any other first-year class. The previous high of four women in 1964 is surpassed this year with a total of six.

The students come from 34 counties and 8 other states and represent 23 colleges and universities.

A research animal farm is being proposed the University of North Carolina. The 1967 General Assembly will be requested to provide \$220,000 to help develop the farm near the campus.

Dr. James R. Pick, Jr., director of the Laboratory Animal Facility at the School of Medicine, said the proposed farm would be used for domestic animals such as horses, cattle, sheep, goats, swine, and poultry. It would be used to condition certain species of non-human primates such as monkeys, baboons, and chimpanzees.

Colonies of animals with metabolic and degenerative diseases similar to those in humans would be established at the farm. And the farm facilities would house animals used in long-term research studies.

"The opportunity to conduct ecologic studies and to observe animal behavior in a near-natural habitat would be afforded by the farm," Dr. Pick said.

* * *

Two Australian surgeons were special visitors at the UNC's Hand Rehabilitation Center recently.

Dr. John T. Hueston and Dr. Bernard O'Brien, both of Melbourne, Australia, were the physician visitors. Dr. Hueston, who has charge of plastic surgery at the University of Melbourne, remained for five days.

* * *

An unusual, unsuspected relationship of a trace metal to blood-clotting factor was reported in Chicago at the Third International Congress of Human Genetics by two geneticists from the University of North Carolina School of Medicine.

They discovered, as a result of studies of the "complementation" phenomenon in hemophilia (the bleeding disease), that manganese has a peculiar protective effect on the antihemophilic factor (AHF) in the blood plasma of normal people. The metal protects against the destructive action of two enzymes, they said.

The meaning of the discovery isn't clear yet, according to Dr. John B. Graham, professor of pathology, and Emily M. Barrow, research associate in pathology.

The manganese effect was discovered while studying the relationship between two hemophilias—classic hemophilia and von Willebrand's disease—which are similar from a laboratory standpoint but clearly different from a genetic standpoint.

* * *

Merit scholarships for eight medical students have been announced by Dr. Isaac M. Taylor, dean of the University of North Carolina School of Medicine.

The Walter Reece Berryhill Scholarship, established by the UNC Medical Parents Club in honor of Dean Emeritus W. Reece Berryhill, was awarded to Gerald Wayne Blake of Jacksonville.

The H. McLeod Riggins Scholarship was presented to Thomas Ladd Henley of New York City. The award honors Dr. H. McLeod Riggins of New York City (Class of 1922).

Alumni Loyalty Fund Merit Scholarships, supported by funds from medical alumni, were awarded to two students from each of the three upper classes:

Seniors—Jerry Lee Norton of Lake Toxaway and Barbara Jean Parks of Lexington.

Juniors—Stephen Wiley Young of Angier and Michael David Lutz of Reading, Pa.

Sophomores—Henry Moore Middleton, III, of Raleigh and William Thomas Rowe, Asheville.

* * *

Dr. John B. Graham, professor of pathology and chairman of the policy board of the UNC Population Center, has been appointed an Alumni Distinguished Professor, and Dr. Edward McG. Hedgpeth, director of the UNC Student Health Service, has been designated the Taylor Grandy Professor of Clinical Medicine.

The appointments were announced by Chancellor J. Carlyle Sitterson with the approval of President William C. Friday and the University board of trustees.

* * *

The UNC medical school's two-way radio conference program resumed its twice weekly broadcasts on October 11 with Dr. Janet J. Fischer of the Department of Medicine discussing office microbiology.

The broadcasts again this year are scheduled on Tuesday to one section of the state and on Thursdays to the other section.

Broadcasts, originating in the studio at the medical school, are relayed throughout the state by six FM radio stations on Tuesdays and by three FM stations on Thursdays.

Participating medical groups are in Burlington, Charlotte, Tarboro, Goldsboro (two groups), High Point, Sanford, Kinston, Greensboro, Mount Airy, Rocky Mount, Rockingham, Albemarle, Durham, Waynesville, Washington, Lenoir, Wilmington and Smithfield.

* * *

Correction

Two errors appeared in the News Notes from the University of North Carolina for August, 1966.

Three awards rather than two were received by Hugh A. (Chip) McAllister, Jr., of Lumberton in special graduating exercises held in early June. They were the Isaac Hale Manning Award as the outstanding member of the graduating class; the Deborah C. Leary Memorial Award for the outstanding paper submitted in the Senior Elective Program; and the George C. Thrasher, Jr., Award for the most outstanding performance and ability in psychiatry.

The second error occurred in the title of a paper by Dr. J. Thomas Fox, Jr., of Asheville, one of two winners of the Anclote Manor Awards for outstanding work in scientific reports submitted as part of their three-year residency training program. The title should read: "Student Health: Psychiatry at the University of North Carolina, 1956-1964."

NORTH CAROLINA CHAPTER AMERICAN COLLEGE OF RADIOLOGY

At the meeting of the North Carolina Chapter of the American College of Radiology held at Southern Pines, Oct. 15, the following officers for 1966-1967 were elected:

President—Dr. Leslie Morris, Gastonia

President-elect—Dr. James F. Martin, Winston-Salem

Vice president—Dr. William Barry, Durham

Secretary-Treasurer—Dr. Ira Bell, Hickory

The next meeting of the chapter will be held in conjunction with the meeting of the Medical Society of the State of North Carolina, at Pinehurst, May 23, 1967.

AMERICAN COLLEGE OF SURGEONS

North Carolina Initiates

Approximately 1,350 surgeons were inducted as new Fellows of the American College of Surgeons in cap-and-gown ceremonies during the annual clinical congress of the organization held in Chicago, Oct. 13.

Those from North Carolina receiving the distinction were as follows:

Drs. Walter L. Bayard, Tryon; Lawrence K. Boggs, Charlotte; Richard F. Bowling, Shelby; Frank J. Campbell, Fayetteville; David L. Collins, Jr., Concord; Dwight G. Davis, Jr., Raleigh; Vincent L. DiRienzo, Rockingham; Robert K. Dyer, Lumberton; Lowell Furman, Boone; Sidney Gardner, Jr., Fayetteville; Alfred H. Garvey, Greensboro.

Also, Drs. Ismael R. Goco, Winston-Salem; Charles F. Heinig, Charlotte; Samuel G. Jenkins, Jr., Elizabeth City; Donald R. Kernodle, Burlington; Ander M. Mumford, Greensboro; William P. J. Peete, Durham; Clyde R. Potter, Washington; Paul J. Simel, Greensboro; Margaret Wilson, Raleigh; Frank C. Wilson, Jr., Chapel Hill.

NORTH CAROLINA HEART ASSOCIATION

Donald C. Rollins, former Raleigh advertising and public relations executive, has joined the North Carolina Heart Association as field consultant to local Heart Associations in 17 western North Carolina counties.

Rollin's appointment was announced by W. James Logan, executive director of the North Carolina Heart Association. Rollins will serve as consultant to local Heart Associations in Ashe, Buncombe, Burke, Cherokee, Caldwell, Clay, Graham, Henderson, Haywood, Jackson, Lincoln, Macon, McDowell, Polk, Rutherford, Swain and Transylvania counties. He will maintain offices in Asheville.

NATIONAL INSTITUTES OF HEALTH

The cooperation of physicians is requested in a continuing clinical study of calcium metabolism and calcium kinetics being conducted by the Metabolism Branch, National Cancer Institute at the Clinical Center, National Institutes of Health, Bethesda, Maryland.

Of interest for this study are patients with calcinosis universalis, hypoparathyroidism, hyperparathyroidism, pseudohypoparathyroidism, and hypercalcemia of malignancy without bony metastases. Patients with roentgenologic evidence of bone disease as well as docu-

mented serum calcium abnormalities would be of special interest.

Patients for this study should be clinically stable, ambulatory, continent of urine and feces, and be willing to participate in metabolic balance studies, including administration of Ca^{47} , during a 30-day admission to the Clinical Center.

Physicians interested in having their patients considered for this study may write or telephone:

James M. Phang, M.D.
Clinical Center, Room 3B-40
National Institutes of Health
Bethesda, Maryland 20014

NATIONAL ASSOCIATION OF BLUE

SHIELD PLANS

Dr. Richard M. Magraw of Minneapolis has received the 1966 Norman A. Welch Memorial Award for his book *Ferment In Medicine*. The award, presented by the National Association of Blue Shield Plans, is given annually to the author of "the most scholarly and meritorious contribution to the literature of medical economics."

The book contains discussions of the impact of specialization, the effects of the hospital on medicine, the importance of the development of non-medical health specialties, automation in medicine, research, and the patient's means of financing health care. It is published by W. B. Saunders Company of Philadelphia.

INDUSTRIAL MEDICAL ASSOCIATION

Recognizing the role of the driver in automobile accident prevention, the Industrial Medical Association has released information on the selection of persons for commercial vehicle driving who are least likely to be involved in accidents.

Health conditions which should be investigated by the industrial physician in the selection of employees for commercial vehicle and transport driving are set forth in a new publication available from the Association. It is stressed that underlying all considerations in the selection of vehicle drivers is the maxim that anyone with a condition that could suddenly incapacitate him should not drive a vehicle.

The report emphasizes the importance of the experience and judgment on the part of the physician who, in spite of guides such as this report, must evaluate each case individually.

The report, entitled "Medical Evaluation of the Commercial Vehicle Driver," was prepared by the Industrial Medical Association's Committee on Medical Aspects of Driver Safety, under the chairmanship of Harold Brandaleone, M. D., New York City. Copies are available from the Industrial Medical Association, 55 East Washington, Chicago, Illinois 60602, at 30 cents per copy.

The Month in Washington

A new minimum wage law is expected to cause hospital and nursing home costs to rise.

It brings about 1.5 million workers in hospitals and nursing homes under the federal minimum wage program for the first time. The minimum wage for them is set at \$1.00 an hour for next year, \$1.15 an hour in 1968, \$1.30 an hour in 1969, \$1.45 an hour in 1970, and \$1.60 an hour thereafter.

The new law also increases the minimum wage for about 30 million workers presently covered to \$1.40 an hour on Feb. 1, 1967, and to \$1.60 an hour on Feb. 1, 1968.

On a related front, Senate Democratic Leader Mike Mansfield (Mont.) said he believed the Health, Education and Welfare Department was going too fast in enforcing racial desegregation of southern hospitals and schools. He told newsmen he supported the Senate's denial of \$500,000 sought by HEW to pay civil rights investigators. He said the Senate wants to see desegregation handled carefully rather than impulsively.

The Senate approved legislation that would give nursing homes more liberal payment for medicare patients. The bill amends the definition of reasonable costs to include return on the fair market value of the facilities. The existing federal reimbursement formula is two percent above operating costs. Nursing home operators contend this is too low.

HEW Undersecretary Wilbur Cohen said the government will watch carefully to determine whether patients are admitted unnecessarily to hospitals next year in order to qualify them for medicare's nursing home benefits. The law requires that nursing home benefits be made available only to medicare beneficiaries who have had a hospital stay of three days or more and only when the nursing home care is considered an extension of the hospital treatment. However, several bills have been introduced in Congress to eliminate the hospital stay requirement.

* * *

The American Medical Association supported a bill that would extend the air pollution program and authorize increased appropriations for it.

In a letter to a Senate subcommittee, Dr. F. J. L. Blasingame, executive vice president of the A.M.A., noted that the association's House of Delegates in June, 1965, had adopted a statement recognizing the health hazards resulting from air pollution and recommending that feasible reduction of all forms of air pollution should be sought by all responsible parties. The pending bill (S. 3112) "can further this end," he said.

* * *

The Senate cleared the path for a new approach to narcotics addiction which would substitute hospital treatment for a long-term prison sentences.

The key to the bill is civil commitment for the addict involved in a non-violent crime. It would provide voluntary pre-trial commitment in lieu of prosecution and compulsory post-conviction commitment in lieu of punishment. In addition, the bill would provide voluntary and compulsory commitment of certain addicts not charged with any crime. The addicts would be committed to the Surgeon General for confinement and treatment in a hospital or institution. Treatment would continue within the community after the addict is discharged.

Sen. Thomas J. Dodd, D-Conn., who for years has studied the problem of narcotics, said the bill "will lead to a wiser, more humane, and more effective treatment of narcotics addicts. . ." He said the Senate was undoing the mistake of 10 years ago when it wrote legislation which made "super-criminals out of many narcotics addicts."

* * *

An industry spokesman said drug makers and distributors will comply with a government request that the number of candy-flavored children's aspirins per bottle be limited to 25.

A limit of 50 tablets per bottle was agreed upon in a government-industry conference in 1955 and has been observed by producers of 95% of all children's aspirins. However, some authorities consider this number now to be dangerous, even lethal under some conditions, when taken by a child.

The House and Senate approved differing versions of the legislation which would ban

the sale of children's toys containing hazardous substances. It was left for a conference committee to adjust the differences.

Both versions also would ban dangerous household substances that cannot be made safe by cautionary labeling. These include such items as a flammable and explosive water repellant blamed for three deaths.

In Memoriam

Theodore Sidney Raiford, M.D.

In the death of Dr. Theodore Sidney Raiford on Sunday, August 28, 1966, Buncombe County lost one of its outstanding surgeons, and the Medical Society of the State of North Carolina one of its most respected leaders.

Dr. Raiford was born in Ivor, Virginia, the son of the late Mr. and Mrs. T. Philip Raiford, November the 25, 1903. He received his B.S. degree from Earlham College in Richmond in 1926, and his M.D. degree from Johns Hopkins University Medical School in 1930. He was a member of the Alpha Kappa Kappa medical fraternity, Phi Beta Kappa, Alpha Omega Alpha, and Sigma Xi honorary fraternities. After an internship at Johns Hopkins, he held a residency at Presbyterian Hospital in New York City for four years. He was an instructor in surgery at Columbia University for four years, and received the degree of Master of Science in Surgery from that university in 1935. He served as a Captain in the Medical Corps of the Army of the United States in World War II.

Prior to coming to Asheville and North Carolina in 1947, Dr. Raiford was engaged in the practice of surgery and pathology in Decatur and Springfield, Illinois. In Asheville he established his practice as a general surgeon with staff membership at Memorial Mission, St. Joseph's, and Aston Park hospitals. He was a consultant in general surgery to the Oteen Veterans Administration, and had served as a consultant in thoracic surgery to the Western North Carolina Sanatorium at Black Mountain. He had served as medical coordinator of the Memorial Mission Hospital 1950 campaign for funds, and later as chief of the medical staff of that hospital in 1957.

He was a diplomate of the American Board of Surgery (1950), a fellow of the American College of Surgeons, and a member of the Whipple Society, the Southern Surgical Association, Southern Medical Association, and the American Medical Association.

The presidency of several medical organizations had been held by Dr. Raiford in recent years: the Buncombe County Medical Society in 1960, the North Carolina Surgical Association in 1961, and the North Carolina Chapter of the American College of Surgeons in 1963. During the years 1964-65 he served the Medical Society of the State of North Carolina as its extremely able president. In addition he had served the State Society in many important committees, was an alternate dele-

gate of the House of Delegates of the American Medical Association, and fathered the organization of the Association of State Medical Association Presidents.

He was active in community affairs, and was a member of the Rhododendron Royal Brigade of Guards, the Elks Club, the Civitan Club, the Executives Club, the Biltmore Forest Country Club, the Mountain City Club, and the Society for the Preservation and Encouragement of Barber Shop Quartet Singing in America. His religious affiliation was with the Society of Friends (Quaker). He was married to Jessica Landrum Beadles in 1952.

It was characteristic of Dr. Raiford's love for his profession and his concern for the welfare of his fellow physicians that his death of a heart attack should occur as he was returning from a conference of the Public Relations Institute of the American Medical Association in Chicago. Stricken while on a plane en route from Chicago to Asheville, he was rushed to a Louisville (Kentucky) hospital where he was pronounced dead on arrival.

Dr. Raiford will long be remembered for his meticulous care of his patients, his unwavering loyalty to the high standards of professional conduct, and his devotion to his colleagues and their welfare. The directors of the Buncombe County Medical Society feel keenly their loss in his passing, and direct that this testimonial be recorded in their minutes, that copies be sent to the Medical Society of the State of North Carolina, to the North Carolina Medical Journal for publication, and that a copy be sent to Mrs. Raiford with a further expression of their sympathy in her bereavement.

Rayford K. Adams, M.D.

Dr. Rayford K. Adams died at the age of 80, after a long illness, at Cabarrus Memorial Hospital on May 31.

He was born in Monroe on February 22, 1886, the son of Henry B. Adams and Fannie Persons Adams. A graduate of Jefferson Medical College, he began his career in the practice of neuropsychiatry at Mercer Hospital, Trenton, New Jersey. He was assistant superintendent of the North Carolina State Hospital in Raleigh from 1915 to 1929; senior resident physician at State Village for Epileptics, Skillman, New Jersey, from 1929 to 1946; and served as assistant superintendent at North Carolina State Hospital at Morganton from 1949 to 1958.

Dr. Adams was certified by the American Board of Psychiatry and Neurology. He was a member of the Burke County Medical Society, the Medical Society of the State of North Carolina, and the American Medical Association.

On the death of Dr. Adams the Concord Tribune said, in part:

"Dr. Adams retired to Concord and made a host of friends in the succeeding years. His passing brought a pall of sorrow to his new-made friends here and to those who were associated with him in his long and professional life elsewhere.

"His contributions to medical science cannot be assessed, but honor is due his memory for the brilliant record of service he gave those institutions with which he was connected most of his life."

Joseph E. Osborne, M.D., D.D.S

Dr. Joseph Evansborne of Rosman, North Carolina, died of a heart attack at his home on May 25, 1966.

Dr. Osborne was born March 25, 1896, in Shelby, the son of Dr. and Mrs. James Ruffine Osborne. He attended schools in Shelby and received his dental degree in 1919 from Atlanta Southern College, now Emory University. He practiced dentistry for about eight years, first in partnership with his father at Shelby and later with the North Carolina Prisons Department. He then decided to become a doctor and took premedical courses before entering the Medical College of Virginia, where he received the M.D. degree in 1930. He served his internship at Grady hospital in Atlanta.

In 1932 Dr. Osborne came to Rosman, in the rugged mountains of North Carolina, and opened his office for the practice of dentistry and medicine. In August, 1935, he was married to the former Miss Edith Culler, a registered nurse, of Perry, Georgia, who assisted him in his practice until his death.

In the early years of his practice Dr. Osborne dispensed his own drugs, since there was no drug store in Rosman. He performed tonsilectomies and minor surgical procedures in his small clinic. All obstetric patients were confined at home, many in remote mountain areas. He often had to go the last few miles on foot. Among the babies he delivered at home were several twins and one set of triplets. He did his own x-ray work and took care of most fractures.

In 1941 Dr. Osborne was inducted into the U. S. Navy, in which he served until April, 1946. His military service took him first to U. S. Submarine Base Hospital at Coco Solo, Canal Zone. After Pearl Harbor he served for 28 months in the Pacific. He then was attached to the Naval Hospital at Camp Lejeune for a few months before being ordered back to sea for a tour of duty lasting 26 months.

Dr. Osborne's hobbies were traveling, flying, photography, big game hunting, and fishing. While serving his country he made one thousand feet of 16-mm films in the war area. One of his favorite films, made at intervals over the years, was entitled "Folks Around Rosman." From his hunting trips in Alaska, the Yukon, Canadian Rockies, Montana, and Wyoming he brought back many fine trophies which he displayed in his office and home. He prized one of these specimens, a large grizzly bear, so highly that he mounted gold crowns on the upper and lower incisors.

For several years he flew his own plane. In 1959 he bought a travel trailer and became a member of the Wally Byam Club International. For two months every summer he closed his office and traveled throughout the United States and Canada with the Wally Byam Club Caravans, serving on the club's medical committee.

Dr. Osborne was a member and trustee of the Rosman Methodist Church. He was a Democrat, a charter member of the Rosman Chamber of Commerce, a 32-degree Mason, a Shriner, and was chief of staff of Transylvania Community Hospital. He remained active in community and civic affairs until his death.

William DeKalb Wylie, M.D.

William DeKalb Wylie, the son of William DeKalb and Eliza Ragsdale Wylie, was born in Richburg, South Carolina, January 12, 1897. He came from a family steeped in the medical tradition, as both his father and grandfather as well as two uncles were physicians.

He attended Davidson College and the University of Virginia and was graduated from the University of Virginia Medical School after having served with distinction with Base Hospital 65 in France in 1918.

He served his internship and residency in medicine at the Buffalo City Hospital, Buffalo, New York, 1924-1926. He was a diplomate of the National Board of Medical Examiners in 1926. Following a year as medical director of the Jackson Health Resort in Dansville, New York, he came to Winston-Salem in 1923 and became associated in the practice of medicine with Dr. S. D. Craig.

By hard work and devotion to duty he built up a large practice of grateful patients. Neither the hour of the night nor inclement weather deterred him from the conscientious care of his patients. He gave much of himself to them and in turn was respected and loved by them.

Dr. Wylie enjoyed hunting and fishing until forced by a coronary occlusion to limit his activities several years ago.

He was a member of Centenary Methodist Church, a member of the Twin City Club, and a former charter member of the Old Town Club; at one time he belonged to the Lions Club. In medical school he was a member of Alpha Kappa Kappa fraternity.

Dr. Wylie was a fellow of the American College of Physicians, the Southern Medical Association, the American College of Chest Physicians, the American Trudeau Society, the American Tuberculosis Association,

the Forsyth County Medical Society, the Medical Society of the State of North Carolina, and the American Medical Association.

He is survived by his wife, the former Miss Sterling Thornton of Virginia, and two daughters, Mrs. Sterling Wylie Carter and Mrs. Elizabeth DeKalb Wylie Rea, Jr., to all of whom he was devoted.

This quietly modest and dedicated man of medicine will be greatly missed by his many friends both in and out of the profession.

Now Whereas, his Creator has seen fit to remove Dr. William DeKalb Wylie from us the 20th of July, 1966, the Forsyth County Medical Society does here by express regret at his passing and extends sympathy to his wife and daughters, and does hereby

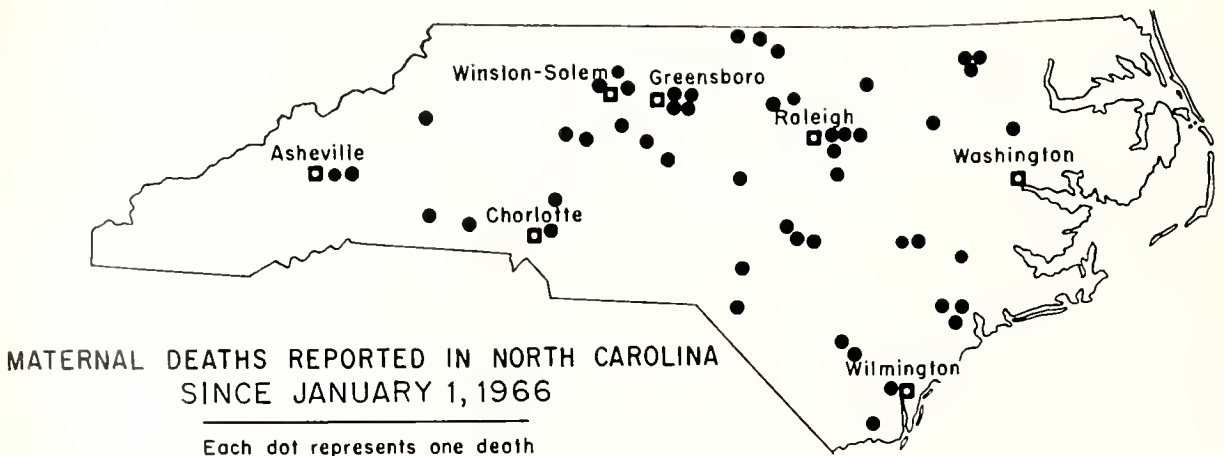
Resolve, That a copy of this expression be sent to his wife, to the Archives of the Medical Society of the State of North Carolina, and that the original be entered into the records of the Forsyth County Medical Society.

About 250,000 new cases of acute rheumatic fever and 140,000 cases of rheumatic heart disease are reported nationally each year, according to the North Carolina Heart Association.

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NORTH CAROLINA

Index
December, 1966
Vol. 27 No. 12



MEDICAL JOURNAL

PUBLISHED MONTHLY BY THE MEDICAL SOCIETY OF THE STATE OF NORTH CAROLINA

IN THIS ISSUE:

Estimation of Disability

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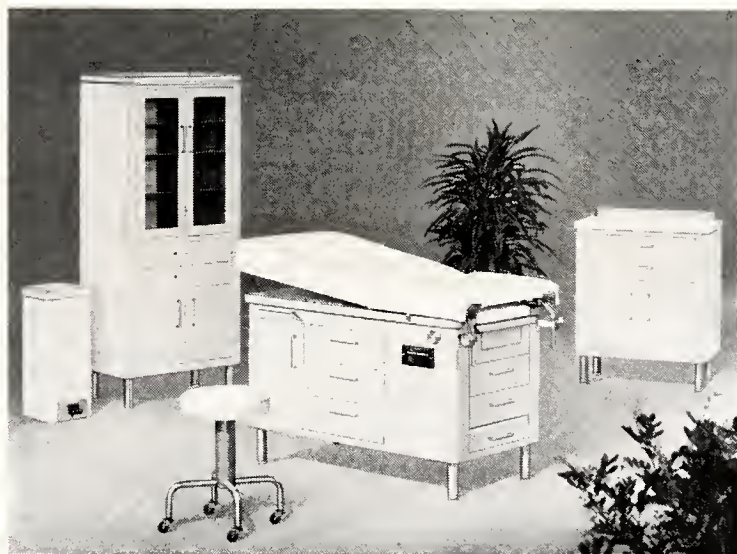
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Symposium on Evaluation of Disability

Foreword

The following papers prepared by Drs. Severn, Martinat and Gaul are a compendium of talks given before the Orthopaedic Section of the North Carolina Medical Society in 1966. These essays attempt briefly and concisely to simplify and standardize what is, in essence, a very complex subject.

The measurement of "man as a machine" has long intrigued medical investigators as well as sociologists and engineers. I recently served on a committee of the American Academy of Orthopaedic Surgeons in preparing a handbook on Disability Evaluation. In the course of this preparation, we conferred with staff committee members of a like committee of the American Medical Association who had prepared the manual on "Disability Evaluation of the Extremities and the Back, Based on Joint Motions." This matter of studying man as a machine was investigated by a select committee at the Princeton Institute of Advanced Study, and the culmination of their findings was that the subject was impossible to dispose of in a logical, mathematical manner.

Thus, it remains an enigma, but we are required by various laws to arrive at some sort of an estimate, at least, as a basis for comparison and compensation. In some countries, notably the Scandinavian countries, very extensive guides are used. These guides take into account such details as occupational loss, educational level for training at a new job, motivation and psychological testing. In our country, particularly our jurisdiction, the law is rather vague, but it simply requires the doctor to give a proposed rating which the Industrial Commission will act

upon. No notation is made of an occupational impairment factor, so this has given rise to many hearings where the Commission itself must adjudicate the bearing of the rating (related to the particular member injured) on the occupation. Perhaps, in future years, our law will be clarified to state whether the occupational factor should be considered by the physician.

The other point that is under continual discussion is the factor of pain. It is my contention that the physician is the best of the trained individuals able to assess pain, and that a measurement of physical impairment based solely on anatomic findings and joint motions should not be the conclusive factor. In the manual on disability prepared by the American Academy of Orthopaedic Surgeons, the following factors relating to this analysis of pain are recommended:*

GRADING OF PAIN AS A SUBJECTIVE SYMPTOM

Grade I—Mild: When there is a firm conviction established through thorough observation and clinical tests that pain actually exists even though there may be no organic manifestations. Pain of this degree does not contribute to physical impairment.

Grade II—Moderate: When the examination revealed definite evidence of a pathological state of the involved structures that would reasonably produce the degree of pain indicated to be present. This degree of pain might require treatment and could be expected to contribute in a minor degree to permanent physical impairment.

Grade III—Severe: When the pathological changes and clinical findings indicate that permanent physical function is limited by pain requiring treatment for relief and contributing extensively to permanent physical impairment.

Presented before the Section on Orthopaedics and Traumatology, Medical Society of the State of North Carolina, Asheville, May 2, 1966.

*Manual for Orthopaedic Surgeons in Evaluating Permanent Physical Impairment, American Academy of Orthopaedic Surgeons, pp. 7-8.

Grade IV—Very Severe: Where the pathological changes and clinical signs indicate limitation of physical function by pain to such a degree that physical impairment is nearly complete."

In presenting these brief papers, it is hoped that some help towards order and uniformity within the broad limits allowed by the Workman's Compensation Act will be

* * *

encouraged among those physicians in the state who voluntarily agree to treat Workmen's Compensation patients and thereby obligate themselves to attempt to assign a disability rating in those cases where there is a residual disability factor.

Chalmers R. Carr, M.D.

Moderator

A Method of Evaluation of Permanent Impairment of the Spine

EDWIN H. MARTINAT, M.D.*

WINSTON-SALEM

The establishment of uniform standards for rating loss of function in injured patients has long been a problem, and one of great complexity when the spine is involved. During the past few years the picture has been further clouded by confusion regarding the terms commonly used in discussing the matter—namely, "impairment" and "disability." Impairment refers to loss of function of a part or all of the body, and relates only to strictly medical considerations. That is to say, this term denotes loss of function alone, without regard to the patient's role in the world.

The term "disability, on the other hand, embraces all the factors, medical and non-medical, which diminish the patient's capacity for everyday activities and gainful employment. In addition to physical impairment, the term takes into consideration the patient's abilities and training prior to injury, and his opportunities for gainful employment in his present situation.

To clarify the distinction further, we might postulate two individuals—one an unskilled uneducated laborer of limited intelligence, and the other a highly intelligent theoretical physicist. Suppose that each of these persons suffers a herniated disc in the course of his occupation and is left with an impairment rating of 20%. The laborer with this rating might very well find himself unable

to perform the work for which he is suited and therefore unable to find employment. Obviously, in this situation the 20% impairment would constitute total disability unless this man could be rehabilitated by retraining or other means and directed into some other gainful employment. The physicist, on the other hand, though having the same physical impairment, would actually have no disability so far as his work was concerned.

The physician's prime responsibility in assigning a numerical value to loss of function is to rate the impairment. Certainly, however, he should be able to recognize disability when he encounters it and to institute rehabilitation of the disabled person when it is indicated.

The problem of rating impairment is two-fold: (1) the amount of existing impairment must be determined; and (2) this impairment must be translated into mathematical terms. This translation has been one of the chief sources of misunderstanding between physicians, and the remainder of this paper will be devoted to an attempt to clarify the problem.

Two or more physicians may be in complete accord as to the medical findings, diagnosis, and prognosis in a particular case, but when they attempt to translate this impairment into percentages, they often find themselves at considerable variance. Fortunately a number of guides are available to help make this translation more uniform: McBride's "Disability Evaluation,"¹ the American Medical Association's "Guide to the Evaluation of Permanent Impairment of the

*Associate Professor, Section of Orthopaedic Surgery; Director, Division of Rehabilitation Medicine, Bowman Gray School of Medicine of Wake Forest College, Winston-Salem, N. C.

Request for reprints, Department of Surgery, Bowman Gray School of Medicine, Winston-Salem, N. C. 27103.

Extremities and Back,"² The Veterans Administration's "Schedule for Rating Disabilities,"³ our own State Society's "Guide for Permanent Disability Evaluation of Industrial Accidents,"⁴ and the most recent, the American Academy of Orthopaedic Surgeons "Manual for Orthopaedic Surgeons in Evaluating Permanent Physical Impairment."⁵

Even with the use of these guides some difficulty remains, especially with regard to the spine. This is particularly true for the physician who is called upon to give ratings only occasionally. The guide proposed here⁶ has used as a basis all the aforementioned publications. It should be used only as a guide to help the physician arrive at an accurate rating of impairment, not as a scale of absolute values.

The factors to be considered are pain, local clinical changes in the back, roentgenographic changes, neurologic deficit, and prognosis.

1. *Pain* is often the symptom that first brings the patient to the physician, that in many respects controls his treatment, and that is often the major factor which prevents him from returning to work. Nevertheless it is quite often the most controversial point in rating impairment of the back. The question is frequently asked, "Can you measure pain?" I feel that as physicians we are better qualified to evaluate pain than anyone else and certainly should use our evaluation of pain as part of our interpretation. For purposes of rating, pain is classified as mild, moderate and marked, and values are assigned accordingly.

2. The *local clinical changes* are loss of motion, atrophy in the musculature of the back, weakness of the musculature about the spine, tenderness in the region of the spine and its associated structures, muscle spasm in the paraspinous and associated muscles, and signs of nervous tension such as those elicited by the straight-leg-raising test and the femoral-nerve stretch test.

3. *Roentgenographic changes* are divided into vertebral fractures, changes in the disc space, instability, and degenerative changes.

4. *Neurologic deficit* refers to the changes found in the extremities as they are used

for substantiating a diagnosis of back impairment. If they are severe enough to cause loss of function in an extremity, they should be rated as impairment of the extremity. These findings include motor, reflex, and sensory functions.

5. *Prognosis* refers to those conditions which in themselves may not produce positive findings, but which we know give rise to impairment of function. An example is a confirmed diagnosis of herniated disc, with or without resection and with or without spinal fusion.

After the factors which may cause impairment are listed, each is given a numerical value. These are not true impairment values and should be used only to indicate the relative importance of the changes present. A certain amount of interpolation should be done. For instance, severe spasm in the muscles of the back is given a rating of 12; if the spasm is moderate, the rating perhaps would be 8; if mild, 4, etc. The same procedure can be applied to the other factors.

After all the elements causing impairment have been added, the totals are divided by the set of factors. For the lumbosacral area the total is divided by two, for the cervical area by three, and for the dorsal and sacrococcygeal areas by six. It has been found that these factors tend to give a relatively true value to each area of the spine as it relates to bodily impairment.

It should be stressed again that these figures are not absolute values; they are designed merely as a relative guide to more accurate rating.

Two cases are used to illustrate the use of the guide in estimating impairment. It will be noticed that in some areas there is disagreement between the values reached by different methods of rating. In the system proposed here, rather low impairment ratings are given the dorsal and sacrococcygeal areas of the spine. It is my feeling that injuries in these areas do not give rise to as much impairment as do injuries in other parts of the spine, and this system was designed to take this factor into consideration.

Table 1
Guide for Evaluation or Permanent Impairment of the Spine

Pain		Local Clinical Signs	
Mild	5	Loss of motion	8
Moderate	10	Atrophy and weakness	4
Marked	15	Tenderness	6
		Spasm	12
		Nerve tension signs	5
X-ray Changes		Neurologic Deficit	
Vertebral fractures	20*	Motor	5
Changes in disc space	5	Sensory	5
Instability	20	Reflex	5
Degenerative changes	5		

Prognosis

Herniated disc — no surgery — good recovery	10
Herniated disc — surgery — good recovery	10
Spinal fusion — good result	10
Herniated disc — surgery and spine fusion — good result	15

Changes are described as mild, moderate or marked and numerical values assigned accordingly.

Example: Severe tenderness	6	Moderate tenderness	4	Mild tenderness	2
----------------------------	---	---------------------	---	-----------------	---

This interpolation is done with all findings.

Vertebral Fractures*

Compression of body:	10% compression	5
	25% compression	10
	50% compression	15
	75% compression	20

Posterior Elements

Undisplaced	10	
Displaced	20	(Excluding spinous and transverse processes)
Spinous processes	5	
Transverse processes	5	(Spinous and transverse processes; single or multiple, not additive)

For Fractures

Add for each involved vertebra 50% of value. Take most involved vertebra at full value. The last two thoracic vertebrae are included as part of the lumbosacral spine for evaluation purposes.

Factors—to obtain percentage of permanent impairment of the whole body

I. Lumbosacral area	Divide by 2
II. Cervical area	Divide by 3
III. Dorsal area	Divide by 6
IV. Sacro-coccygeal	Divide by 5

Case 1

A man with a herniated disc at the lumbosacral interspace underwent laminectomy and excision of disc. Residual symptoms consisted of mild back pain, moderate tenderness of the back, roentgenographic evidence of narrowing of the disc space, and diminished ankle jerk. These findings were rated as follows:

Mild pain	5
Moderate tenderness	4
Disc space narrowing	5
Diminished ankle jerk	2.5*
Diagnosis of disc herniation	10.0
	<hr/>
	26.5
Divide by factor of 2 for lumbar area: 13.25% of body.	
*Total absence of ankle jerk would be 5 per cent.	

McBride

Nucleus pulposus syndrome, cervical or lumbar; with surgery, without fusion.

a. Disabling pain satisfactorily relieved, no relapse after 6 months; resumption of regular labor: 0% of body

b. Persistent lumbosacral soreness after 6 months aggravated by heavy lifting; extra heavy work not advisable: 20% of body.

This case should be rated between the above values.

American Medical Association

	Impairment of Spine	Impairment of Whole Body
Disc lesion, slight limitation of motion		5
Flexion	2	
Extension	1	
Right lateral flexion	2	
Left lateral flexion	2	
Right rotation	2	
Left rotation	2	6
	<hr/>	<hr/>
	11	11

North Carolina Medical Society

Ruptured lumbar disc. Removal of disc, free of back and leg pain, no weakness—10% impairment of spine.

Postoperative: same as above, but slight residual back and leg pain—15% to 25% impairment of spine.

This case probably would be rated between the above values, since there is no residual leg pain—about 12.5% of spine.

Veterans Administration

Intervertebral disc syndrome. Free of back and leg pain, no weakness—10% impairment of spine.

American Academy of Orthopaedic Surgeons

Neurogenic low back pain from lumbar disc injury.

Good results of surgical excision of disc, no fusion, no persistent sciatic pain—10% impairment of whole body.

Surgical excision of disc, no fusion; moderate persis-

tent pain and stiffness aggravated by heavy lifting with necessary modification of activities—20% impairment of body.

This case would fall somewhere between the above categories.

Note that to arrive at a close degree of accuracy, a certain amount of interpolation is necessary. In most systems, this occurs as an end point adjustment—that is, mild recurrent symptoms; moderate recurrent symptoms. It is felt that the author's system of interpolating each finding — for example, mild spasm, severe spasm, etc.— can be applied more accurately to an individual case.

Case 2

A man suffered compression fractures of the fifth and sixth cervical vertebrae. Residual findings were evaluated as follows:	
25% compression fracture, C-5	10.0
10% compression fracture, C-6 (50% value)	2.5
Narrowed disc space, C-5-C-6	5.0
Mild degenerative changes C-5-C-6	2.0
Mild pain	5.0
Mild loss of motion	3.0
	<hr/>
	27.5

Divide by 3 for cervical area—9.16% impairment of body.

McBride

Fractures of one or two vertebral bodies without cord involvement. Full recovery to the extent of useful strength, free motion, no muscle spasm or disabling pain, up to 75% normal. Impairment caused by vertebral bodies of the cervical region—17% of body.

American Medical Association

	Impairment of Spine	Impairment of Body
Fractures of two vertebral bodies	20	
Mild limitation of motion	6	
	<hr/>	
	32	19%

Veterans Administration

Vertebral fracture	10
Slight loss of motion	10
	<hr/>
	20% of body

North Carolina Medical Society

Single, healed cervical spine fracture, with little or moderate anterior compression and without neurologic abnormalities	10
Two or more vertebrae, each 50% of above	5
Restricted motion and pain, mild	2
	<hr/>
	17% of body

American Academy of Orthopaedic Surgeons

Fracture: vertebral compression 25%, one or two vertebral adjacent bodies, no fragmentation, no involvement of posterior elements, no nerve root involvement, moderate neck rigidity and persistent soreness—20% impairment of whole body.

With only slight limitation of neck motion, this case should probably receive lower rating than above.

Summary

To fulfill his responsibilities in the evaluation of impairment, the physician must:

1. Evaluate the permanent loss of function as early as possible.
2. Accurately translate this loss into percentages if required by law.
3. Evaluate the effect of the impairment on the individual patient and if it is found that this impairment is going to lead to dis-

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Evaluation of Impairment of the Upper Extremities

JOHN STUART GAUL, JR., M.D.

CHARLOTTE

Impairment may be defined as an anatomic functional defect of a part of the body, while disability represents the personal handicap resulting from the physical impairment. The disability resulting from the same physical impairment may differ widely from one person to another. For example, a business man may lose a finger without significant detriment to his personal capabilities, whereas a musician suffering the same loss might be totally disabled from the standpoint of his career.

Evaluation of disability is becoming increasingly important, not only in the settlement of insurance claims but more important, medically speaking, in determining the need for and planning reconstructive surgery, prosthesis training, etc.

It has been said that "the arm exists for the hand." Loss of the arm at or above the humerus automatically constitutes from 95 to 100 per cent impairment of the upper extremity, while amputation between the elbow and forearm easily represents from 80 to 90 per cent. Thus evaluating impairment of the

ability, advise a program of rehabilitation and see that it is instituted early.

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upper extremity largely boils down to evaluating disability of the hand.

Losses by Amputation

The first step in evaluating the disabled hand is to note any losses by amputation (terminal, transverse defects, total in extent), recognizing that the thumb represents from 38% to 40% of the hand, the index finger about 25%, the middle finger 18% to 20%, the ring finger 12% to 15%, and the little finger 8% to 10%. Notes that these figures add up to more than 100% of the hand. The reason is that the loss of one finger will actually impair the function of the other fingers to some extent, since the thumb and fingers are interdependent in normal hand function. For example, a missing index finger makes it necessary for the thumb to strain a little harder in the pinch maneuver.

In considering the amputation of digits at progressively proximal levels, we note that impairment accumulates quickly, since it is through the ends of the fingers that the sensation of touch is largely perceived. Thus, amputation of the distal phalanx of the finger causes 50% impairment of the finger,

and amputation of the two distal phalanges results in 100% impairment, allowing no credit for the remaining proximal segment. In actual experience, many people with proximal phalangeal stumps regard them as useless, and some request ray resection (often the thumb's alignment does not allow it to rotate and pinch against such a stump satisfactorily.)

To evaluate the remaining parts of the hand after amputation, it is necessary to understand the way the hand functions. Primarily, this function consists of pinch, grasp, release, and hook maneuvers. In order to perform these maneuvers the hand must have four anatomic modules functioning and intact: (1) comprehensive sensation in the finger tips; (2) fingers that flex, (3) fingers that extend, and (4) a strong opposable thumb with an extensible distal joint. We therefore look for demonstrations of these primary functions and the presence or absence of the anatomic modules that make these functions possible, estimating impairment in proportion to the degree that any of the functional modules are defective.

1. *Critical sensation* is the most important of these four modules and also the most difficult to evaluate objectively. Complete loss of sensation in a digit or a portion of the hand can easily cause from 90% to 100% disability of that part. With experience and attention, sensation can be fairly well evaluated from objective clinical observation. The completely denervated finger tip is smooth in appearance and to touch. It is devoid of perspiration, since sudomotor fibers are closely associated with the various sensory nerve fibers. In addition, the clusters of nerve endings under the skin of the finger tip may be atrophied, giving the finger a tapered appearance.

Sweating almost always implies the presence of some sensation, though it may be far from normal. Excessive sweating is usually associated with some degree of hyperesthesia, which also implies some, though by no means complete, disability, and which often is temporary. Since the smooth, dry finger pad is clear objective evidence of nerve injury with anesthesia, the ninhydrin test is usually unnecessary.

2. Loss of the ability to flex the fingers, as seen in some nerve and tendon injuries, imparts a severe disability to one or more digits or to the hand, which, if complete, represent by itself about 90% disability of the finger or hand so involved.

3. Loss of the ability to extend the fingers, though disabling, is definitely less so than loss of flexion. The fingers that remain flexed often retain an extremely useful hook and pinch function, and sometime grasp. Generally speaking, the loss of extension of the fingers would seem to constitute impairment ranging between 40% and 50%. For example, the claw-hand resulting from an isolated injury of the ulnar nerve, with flexion contractures of the fourth and fifth fingers, rarely comes to surgical correction, apparently because the victims do not consider the condition sufficiently disabling to warrant surgical treatment.

4. Total impairment of the thumb can disable the hand easily as much as 50%. That the impairment of such a hand may exceed the value assigned the thumb alone is explained by the fact that the fingers themselves are disabled, lacking a strong thumb base with which to grasp or a thumb tip with which to pinch. Partial impairment of the thumb will result in less disability of the hand.

Evaluation of the upper extremities should not be discussed without a review of the generally recognized impairment that results from complete ankylosis of the various joints. If the joints are ankylosed rigidly in the position of maximal function, the generally accepted impairment values are as follows:

- Shoulder, ankylosed with the arm close to the chest in the neutral position—50% of the upper extremity
- Elbow, at either a right angle or the ideal angle for the particular circumstance of the patient—50% of the upper extremity
- Radio-ulnar joint, in mid-position (supination and pronation)—35% of the arm below the elbow
- Wrist joint, in slight extension—35% of the arm below the elbow (usually occurs in conjunction with ankylosis of the radioulnar joint)
- Metacarpophalangeal joint of a digit, in 20 to 25 degrees flexion—45% of the digit
- Proximal interphalangeal joint, in 40 to 50 degrees flexion—50% of the digit
- Distal interphalangeal joint, in 20 to 30 degrees flexion—25% of the digit.

Impairment resulting from partial stiffness is proportionately less, although associated pain may nullify the benefit of such motion. Joints completely stiff in less than optimum position, however, cause greater impairment of the part.

For clarity, impairment values should be ascribed to the smallest distal part of the extremity involved; for example, impairment is ascribed to the separate digits when the metacarpal, carpal, and proximal segments are not involved.

Finally we note that when multiple anatomic injuries exist—say a missing index finger, a tender palmar scar, and a partly stiff wrist—the most severe loss is first subtracted from the 100% function of the normal extremity. The other impairments are then considered as losses from “the remainder” of that part of the extremity. In this

* * *

case, that part is the hand and forearm, or upper extremity below the elbow. (In the quaint terminology of the North Carolina Industrial Commission, “the hand” extends as high as the elbow.) Thus, in the hypothetical case mentioned above, the impairment (or permanent disability, in Workmen’s Compensation cases) would be evaluated as follows:

Total loss of index finger	25%
Tender palmar scar estimated at 5% of “hand,” times 75% remainder of hand—3.75%	4%
Partial stiffness of wrist estimated at 20%, times 71% remainder of the hand—14.2%	14%
Total impairment of hand and forearm	43%

Summary

Evaluation of permanent impairment of the upper extremities is discussed, and a hypothetical case involving multiple injuries is used to illustrate the method of estimation.

Evaluation of Disability of the Lower Extremities

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Any physician whose practice includes determinations of disability in this state must be acquainted with two pamphlets: (1) “Guide for Permanent Disability Evaluation of Industrial Accidents,” published by the Medical Society of the State of North Carolina in 1960; and (2) “The Medico-Legal Code of North Carolina,” issued jointly by the State Medical Society and the North Carolina Bar Association in 1962.

This discussion on evaluation of disability of the lower extremities will be largely restricted to Workmen’s Compensation cases. Within this category of injuries there is a base line, prescribed by law, fixing the value of any part of the anatomy. Admittedly, the legal terminology does not always agree with the true anatomic structures as understood by physicians. For example, under the state code the foot does not stop at the ankle but extends upward to the level of the insertion of the hamstrings.

In evaluating disability in Workmen’s Compensation cases in North Carolina, it

must be remembered that the law does not make provision for the usefulness of any part of the anatomy in a particular occupation. A concert violinist who loses the little finger of his left hand, although totally disabled for pursuing his career, would be compensated only for the loss of his left little finger.

Certain basic principles have been established for evaluating disability of the lower extremities. Orthopedists of this state have agreed that whenever a fracture enters a weight-bearing joint it must be assumed that the structure has incurred a minimal disability of 10%. The disability can be much greater, of course, if the joint is disrupted to any degree. It is felt that any fracture extending into the joint would leave some residual post-traumatic arthritis.

Also prior to further evaluation, any inequality in the length of the legs secondary to injury must be accurately measured. A disparity of less than 1/2 inch should not in itself cause any disability. For differences of more than 1/2 inch, ratings can be obtained from the North Carolina Guide. When the correct value has been noted it is added to

the percentage of impairment of motion of the involved joints. To repeat: the percentage of disability caused by shortening of the leg is added to the residual disability of adjacent joints, and not as a percentage of the remainder of the extremity.

Each joint of an extremity must be rated according to limitation of motion and degenerative changes. The Guide states that ankylosis of the hip in optimum position should be rated as 50% disability of the entire leg. Similarly, an excellent result achieved by arthroplasty has been given a rating of 40%. Any malalignment—or in the case of arthroplasty, limitation of motion—would necessarily increase the rating.

According to the above Guide, disability attending ankylosis of the knee in optimal functional position is rated as 50% of the leg. Malposition again will increase the rating. In the case of the knee as of the hip, certain suggestions have been outlined in the Guide, so that any physician in this state should be able to arrive at a reasonable percentage and not have to guess blindly at what the rating should be.

Under the North Carolina Workmen's Compensation Act, any disability below the tibial tubercle or insertion of the hamstrings is regarded as a disability of the foot. While physicians and anatomists may not agree on this ruling, it is the law and must be observed. This rule, of course, does not apply in liability cases not subject to the Act.

Ankylosis of the ankle in optimum position can be assumed to result in disability of 40%, while a fusion of the hindfoot, such as triple arthrodesis, is given a rating of 30%. A successful pan-talar arthrodesis is rated at 60%. This figure is roughly derived from the 40% disability assigned the ankle. The fusion of the hindfoot gives an additional disability of 30%. This figure times the remainder of the foot (60%) equals 18%, which added to the 40% ascribed to the ankle totals 58% or roughly 60%—the figure given above.

Fixation of the foot in the varus position exerts excessive pressure on the lateral aspect of the plantar surface, thus greatly impairing the usefulness of the extremity.

Fractures of the mid- and forefoot probably should receive a minimal rating of 5% because of changes in a weight-bearing structure. I personally feel that simple avulsion fractures do not belong in this category and should not produce any permanent disability. Once again, any major disruption of this part of the foot should be taken into full consideration.

Ankylosis of the joints of the toes should be given a disability rating of 50%. As in the case of fingers, amputation of a toe should probably receive a rating of 25% for the loss of any bone, 50% if proximal to the visible nail bed, and 100% if proximal to the distal phalanx.

On occasion the examiner is asked to evaluate an extremity as a leg instead of a foot, or a foot instead of a toe. This can be done readily without materially changing the method of rating if it is remembered that total disability of a leg entitles the worker to 170 weeks' compensation; of a foot, 144 weeks; of the great toe, 35 weeks; and of any other toe, 10 weeks. By a simple process of arithmetic the changes can be made rapidly.

The North Carolina Orthopaedic Association has been and is still working to achieve a more accurate evaluation of the difference between the loss of an upper extremity and the loss of a lower extremity in today's industry. It is generally conceded that the loss of a hand constitutes a far greater handicap than an above-the-knee amputation, yet in compensable weeks it is allowed only 200 as opposed to 170 for the latter. Since any change in the law will have to be approved by the General Assembly, the effort will be time-consuming and hard to initiate.

Summary

Any physician dealing with disability cases should have in his office the "Guide for Permanent Disability Evaluation of Industrial Accidents." This guide is not only necessary in compensation cases, but is useful in estimating disability under any circumstances. The burden of proof should be on any physician who disagrees with such a guide, although admittedly there are on occasion other factors which could alter cases.

Occupational Medicine: Current Views

M. C. BATTIGELLI, M.D.

CHAPEL HILL

It is relevant to state that industrial medicine is not merely medicine *in* industry but rather medicine *for* industry. If general medicine finds its fundamental task in restoring health to the sick, if preventive medicine attempts to shelter man from loss of health, industrial medicine aims at maintaining a man in good health and at work. Europeans, with their pedantic love of specific words, call it "medicine of work," as can be verified by a rapid review of terminology: *la médecine du travail* of the French, *arbeitsmedizin* of the Germans, *medicina del trabajo* of the Spanish, and *medicina del lavoro* of the Italians.

Being practitioners of medicine for industry, industrial physicians are interested in man as a source of energy, as a producer of work: thus, industrial physicians appreciate better than many of their colleagues in other specialties the economic value of health. A decrement of health is more evident to the industrial physician as a reduction of work output, a cause of waste which will be recorded somewhere as a loss of profit.

Health is an important ingredient of profit. There is nothing more fundamental to our North Carolina business than earning a profit. Every departure from health, as even a mild incident of sickness, or an impairment of health, has economic relevance to our state's industry and its management.

Industrial medicine has the responsibility to examine and identify these limitations of health, to describe them in terms of employability, to provide for proper job placement, and to secure medical supervision for industry. Work efficiency, work attendance, and work satisfaction become in this view an es-

sential part of medical management. Yet, do management, workers, and occasionally some of our professional colleagues readily identify us industrial physicians as the specialists of maintenance of manpower which we feel we are? All too often our professional concerns, as industrial physicians, appear of remote relevance, or at least less than essential, to the welfare of our people. All too often, industry, workers, and physicians fail to realize that every instance of employment, of relocation, of resumption of work after illness, of promotion, or of retirement involves necessary medical decisions.

It is known that the mere fact of training, and of fitting employees to responsible jobs, represents an investment which involves considerable costs to the employer. Employees and their health endowments become, in this issue, part of the investment of industry. As long as physicians' decisions affect this basic commodity, one can readily state that few are the medical decisions, no matter where issued, which could be considered irrelevant to industry. In a way, every time a doctor treats a worker he assumes a responsibility in industrial medical management. Good health, health limitations, and health failures are indeed important factors of industrial business and liability.

A worker, in a schematic sense, presents to industrial management three distinct liabilities. First, as an operator, his relative health endowment, motivation, and freedom from handicap critically classify him as a more or less desirable investment. Secondly, in his record of morbidity, the worker confronts industry with problems of legal as well as health liabilities in view of possible environmental relevance to disease. Finally, as an organism necessitating human maintenance as well as general controls of preventive nature, a worker presents needs for operating costs in terms of a program of health conservation.

It is the purpose of this paper to discuss

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briefly and separately these three aspects of medicine for industry.

1. Employability

Is there not a fallacy in looking at the worker as an ideally healthy, vigorous individual, immune to disease or to the effects of aging? Workers are young and old, healthy and crippled, and even sick, pregnant, or convalescent. Most people, we all agree, need to work. It would be a dangerous and perhaps impossible proposition to consider that only perfectly healthy subjects are employable.¹ From national health statistics, we know a substantial proportion of working people have, in fact, health limitations (see Table 1²).

Table 1²
Health Characteristics of Workers
(USPHS, Vital Statistics, July 1961-June 1963)

	No.	Per Cent
USA labor force	71.5 million	100
Workers over 45 years of age	28.6 million	40
Female workers	24.8 million	35
Workers with one or more chronic conditions	37.4 million	52.4
Workers limited by chronic disability	5.2 million	7.3

Passing a judgment on the specific employability of a subject is fundamentally a quantitative process which requires matching work capacity to work requirements. In fact, to assess the subject's adequacy to the job demand, it is necessary to apply clinico-physiologic rating procedures, whereby the results of his clinical examination and functional tests are expressed numerically or in some categorical grade. Although general practitioners rarely use or need this procedure, every industrial physician is expected to be quite proficient at it. Information obtained from the physical examination, laboratory tests, prognostic consideration, and the response of a subject to exercise, properly monitored,³ can all be compiled in descriptive fashion. Relatively simple devices are available for these assessments, including tests of physical work fitness^{4,5} and of personality and motivation.⁶

Screening candidates for peculiar susceptibility to the effect of environmental stresses occupies, in the pre-employment examination, a critical function. Recognition of increased susceptibility to disease, for instance, or a precarious condition of health such as exemplified by an abnormal G-6-P dehydrogenase activity, congenitally determined, will suggest proper preventive measures, henceforth avoiding disastrous consequences.

2. Liability

Industrial management is confronted with two major aspects of health liability. One is the best known problem connected with work hazards, and needs no particular comment here. Industrial hygiene and clinical occupational health provide the tools for this control.

The second aspect of liability reflects the health needs peculiar to an employee. As long as the employee's health is part of industry's investment, it is also part of industry's liability: workers' endurance, attrition rate, morbidity and mortality are direct concerns of management, and management needs to be informed about them in a meaningful way.

Prognosis is indeed an essential part of measurement in industrial medicine. More and more industrial management expects the physician to predict the health performance of employees. Techniques for the measurement of this aspect of health are today available, and their application to industry has been successfully demonstrated. Ways of predicting patterns of work absence, using morbidity and complaint frequency, have been described⁷, prognostic interpretations of electrocardiographic tracing have been repeatedly used to anticipate morbidity and mortality experiences⁸, and actuarial methods are available to assess the group prognosis of employees⁹. The work experiences of persons suffering with cardiovascular diseases¹⁰ or having a record of mental hospitalization⁶, epilepsy¹¹, and diabetes¹² have repeatedly been analyzed, yielding guidelines of great value for the formulation of prognostic guesses.

Furthermore, health liability in industry concerns the aggravating role increasingly implied in medicolegal experience, when work

and work environment are implicated in the genesis of disease, particularly cardiovascular and chronic pulmonary disorders. The hazards of work are no longer confined to the well known inhalants, the factors of chemical and physical injuries, but appear to creep insidiously through the pathogenesis of many acute and chronic diseases. Myocardial infarction, for one, when occurring during the work shift or when chronologically connected with work, has been repeatedly related to working conditions.¹³ Blood dyscrasia has often been associated with environmental exposure.¹⁴ It is getting more and more difficult to differentiate between facts and speculation, and a certain philosophical attitude is wide-spread, calling work and its environment to play an aggravating role in mankind's illnesses. Increasingly jurisprudential and medical opinions have been led into the sweeping oversimplification of the *post hoc ergo propter hoc* aphorism. It remains the medical industrial officer's responsibility to clarify these issues through careful, repeated, and properly staged measurement of both the environment and the workers' performance. It is his task to distinguish between the facts and the reasonable probabilities on the one hand, and the speculation and abstract possibilities on the other.

3. Health Maintenance Service

The provision of medical assistance for injuries and medical emergencies occurring at work has been a typical and often all-absorbing function of the industrial medical officer. Without minimizing this essential role, an effective program of medical control needs also to concern itself with periodic surveillance of preclinical conditions, especially those related to major causes of death: hypertension, arteriosclerosis, and malignancy. It is unfortunate that this application of preventive medicine has not yet entered in the habit of mind of many clinicians; at least has often failed to generate diagnostic programs aggressively directed to the "silent" patient. Industrial medicine offers to this point an unparalleled opportunity.

Intensive, periodic examinations offer as well an excellent opportunity to service the status of health of workers carrying chronic

conditions: an estimated minimum of 750,000 epileptics, with 60,000 new cases each year (Armed Services sources indicate a total of 1,800,000); 64 cases of arthritis and rheumatism per 1,000 population; and 2 to 3.5 million cases of diabetes. A significant percentage of these people are limited to various degrees in their capacity to work but may still be employable. It is the industrial physician's responsibility to render periodic medical supervision and care while they are at work.

The mortality and morbidity for the major diseases in the population have been relatively well defined and are commonly used in insurance transactions. Information of this type aids greatly in assessing the physical assets and liabilities of an employee. The definition of "poor risk" in the actuarial stage, is always related to the particular setting of environment. Kidney diseases of infectious or lithiastic origin have relatively good prognosis. However, exposure to high temperature, work in tropics, or associated sickle-cell disease may present distinct hazards aggravating or precipitating recurrences of this condition and creating new emergencies.¹⁵ The employment of a cardiovascular cripple may be a risk, but if the case is properly investigated and the risk is then calculated and accounted for, its negative implications are dramatically reduced. In an assorted group of industries, an excellent study performed at the Harvard School of Public Health¹⁶ showed that the disability rate for cardiovascular patients was 5.9 days per year and for diabetics 3.3 days per year. All together, cardiovascular and diabetic workers lost 13.7 days per year—that is, 6.1 days more than the days lost by the matched control group. The excess absences must be weighed against the positive value of keeping a man at work—the work to which he is accustomed and often indispensable—in order to establish a favorable balance. It is not always economical or even possible to hire only ideally healthy employees when a given skill or work experience is urgently required. The Harvard study also shows that two-fifths of these workers did not lose any time at all because of sickness, and one-half lost

less than 5 days for all reasons; that is, they had fewer absences than the average control.

It is the industrial medical officer who, through adequate measurements, can set proper controls upon undue environmental taxation of human tolerance or unjustified physical load. For this control to be adequate, two main elements must be known: the limits and range of the worker's endurance on one hand, and the measurements and control of work stress and environmental characteristics on the other.

Periodic examination remains the best clinical tool to survey and monitor the working population. Its value has not been superseded or minimized by the introduction of other diagnostic tools. A good, systematic physical inventory of health still resides in a skillfully performed clinical examination. It serves not only as a means of measuring and recording health endowment or its deterioration, but as a contribution to effective maintenance of health through education. As Roberts¹⁷ has well said: "... although this quite defies measurement, one of the greatest yields, possibly the greatest, is their educational value. They offer an opportunity to teach the patient, in highly personalized fashion, something about the maintenance and improvement of his health. They direct his attention, at least intermittently, to an asset of untold value that he may otherwise tend to neglect and ignore. They help him to develop the degree of respect for his health, and awareness of it, necessary to stimulate him to have complaints or problems, referable to health, investigated promptly."

Classifying, properly placing, and periodically examining industrial workers, and rating the work conditions and requirements are the basis for a successful program of human health maintenance. With imagination and dedicated effort, this approach not only can be effective in preventing disease and injury and resultant absence from work, but it may bring a deserved professional reward. Identifying biologic risks and environmental hazards, matching health endowment to job requirements, and exercising medical management to the safety and satisfaction of em-

ployees, undoubtedly call for careful measurements. In this area of modern management in science, in medicine, and in industry, industrial medicine may well strive to be identified as one of the important applications of biologic measurement and control.

Summary

Current views of occupational medicine stress the responsibility the general practitioner assumes in managing a worker-patient; the task of preserving manpower for industry and employability for the worker is shared by all physicians involved in the care of adults; industrial physicians have the more direct responsibility of providing guided clearance to employment for all those able to work. This process requires matching health fitness to work requirements; it makes use of quantitative assessment of both health and work parameters.

Industrial medicine contributes to industrial productivity through careful evaluation of health risk, advising industrial management in its investment in manpower.

An integrated form of prognosis, of emerging importance in industry, includes actuarial methods, physiologic measurements, and evaluation of work demands and work hazards.

The traditional and better known duties of the industrial physician, in applying control to the environment and to human endurance, remain to be implemented with newer duties. Techniques of predicting human performance become the major challenge and responsibility of the modern occupational medicine specialist.

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The Surgical Management of Ureteral Injuries

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Injury to the ureters is relatively uncommon. The ureters are comparatively small, well-vascularized structures with inherent mobility and elasticity, and are well protected by their anatomic location in the retroperitoneal compartment. Ureteral injury, however, may occur following blunt external trauma,¹ penetrating or perforating wounds,² urologic instrumentation,³ or damage at open surgery.⁴ Congenital anomalies, neoplasia, obstruction, infection, and previous surgery or irradiation increase ureteral injury.^{5,6}

By far the most common cause of ureteral injury is surgical trauma.⁷ The course of the ureters through the bony pelvis and their immediate proximity to the colon, urinary bladder, and internal genital organs render them susceptible to surgical injury in the course of treatment of diseases of these organs and organ systems. These internal surgical injuries may result from perforation, ligation, angulation, division, or clamping of the ureter. They may be suspect at the time of surgery, rendering immediate repair possible.^{8,9} In blunt trauma, the ureter may be crushed against a lumbar transverse process. External injuries more commonly produce,

ureteral trauma by penetrating, perforating, or avulsing the ureter. Further injury may result from injudicious catheterization, instrumentation, or transurethral resection or electrocoagulation.

Injury to the ureter is frequently heralded by pain, fever, hematuria, and the development of a mass in the flank. Fistulae may develop early or late. The diagnosis and localization of injuries to the urinary tract demand thoughtful application of urographic, cystoscopic, and occasionally angiographic techniques.^{10,11} For injuries discovered at operation, the sophisticated diagnostic methods available are generally unnecessary. In the presence of obstruction, nonfunction, or urinary fistula, however, urographic studies are essential.

A special word should be said about the patient who becomes anuric following abdominal or pelvic surgery, particularly hysterectomy. Oliguria may be the result of extracellular volume depletion or acute tubular necrosis; but anuria, complete cessation of urinary flow, indicates bilateral ureteral obstruction and demands immediate urologic investigation and intervention.

Surgical Techniques

Ureteral injuries may be treated by a variety of methods. Special consideration is

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given to the patient's age, general medical condition, prognosis in terms of primary disease, total renal function, and type, location, extent and duration of injury. The surgical techniques involved may be categorized as: (1) primary repair with or without resection; (2) re-implantation of the ureter into the bladder or renal pelvis; (3) partial substitution of the ureter by bladder flap, or total substitution by an isolated segment of isoperistaltic ileum;¹² (4) urinary diversion by transureteroureterostomy;¹³ cutaneous ureterostomy, nephrostomy, ureterosigmoidostomy or ileal conduit; and (5) ipsilateral renal ablation by nephrectomy or total ureteral ligation.

The most effective and satisfactory method of managing surgical injuries involves prompt repair of the ureter itself.¹⁴ Urinary diversion, either temporary or permanent, is not a satisfactory alternative to early reconstructive attempts. The ideal procedure for repairing ureteral injuries at any level is resection of the damaged segment and rejoining the severed ends, employing a spatulated oblique anastomosis to effect and insure maximum circumference of the ureter at the suture line¹⁵ (Fig. 1).

The matter of ureteral stenting has received a great deal of attention from a number of authorities.¹⁶ We prefer to use internal stents of relatively inert substances — red rubber or silastic catheters. One end is passed up the ureter to the renal pelvis, while the lower end is passed down the ureter and coiled in the bladder. The stent may be left in this position for as long as three weeks, permitting continuous internal drainage and splinting without risking the infection that might attend the use of an exteriorized catheter. Penrose drains, employed extraperitoneally at the site of ureteral reanastomosis, are advanced and removed as rapidly as possible. The internal stent is removed cystoscopically after an interval of not less than ten days.

Stenting catheters that issue externally have the disadvantage of serving as a portal of entry for urinary infection; however, they may be useful in permitting direct measurement of renal function and in providing access for irrigation, should this prove neces-

sary. When such stents are employed, they can be used as nephrostomies, pyelostomies, ureterostomies, or ureterocystostomies. Occasionally, stenting catheters may be brought down the ureter and out through the urethra in conjunction with an inlying Foley urethral catheter for stabilization. Straight whistle-tip catheters of red rubber and silastic, the least reactive varieties, are preferred. T-tube

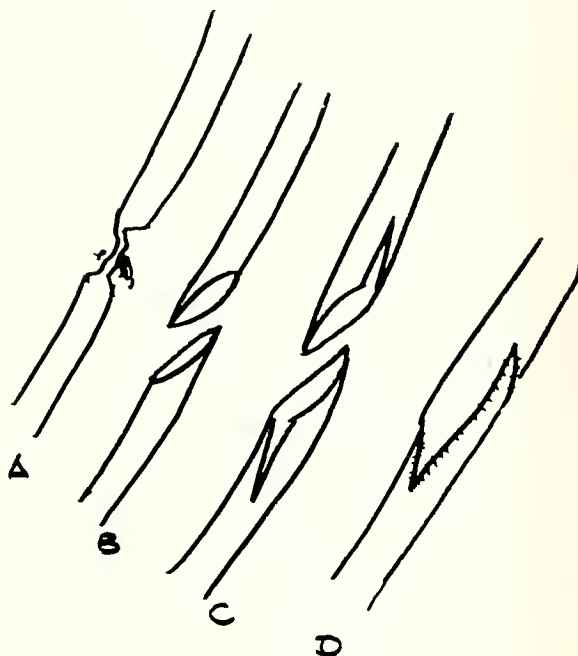


Figure 1

A. Area of ureteral stenosis, stricture, ligation, division, fistula or other area demonstrated.

B. Injured area excised, opposing proximal and distal ureteral segments cut obliquely, and ureter mobilized to permit reanastomosis.

C. One centimeter vertical incisions in proximal and distal segments, effecting spatulation to permit double-ellipse closure.

D. Double-ellipse closure by interposition of spatulated opposing ureteral segments.

drainage is mentioned to be condemned because of the tube's tendency to kink at the point where it emerges from the ureter.

Occasionally, particularly in uninfected cases, primary repair without ureteral splinting may be desired. Here, spatulated reanastomosis with a proximal venting ureterosigmoidostomy or pyelotomy may be quite effective. When such a vent is employed proximal to the suture line, a rubber drain of the Penrose type should be placed extraperitoneally from

the vent site through the flank. This drain should not be removed until all drainage has ceased for at least three days.

Injuries to the lower third of ureter may be managed efficaciously by ureteroneocystostomy. As much of the proximal ureter as possible is salvaged, the ureter is mobilized, and reimplantation is effected by one of the standard techniques. Usually a submucosal tunnel of some length may be developed, insuring against future vesicoureteral reflux, although reflux is not a major problem following ureteral reimplantation in adults. Stenting catheters are usually employed and may be coiled within the urinary bladder or brought out transurethraally or suprapubically for drainage.

If there is a deficit in the length of viable terminal ureter, precluding direct ureteroneocystostomy, a substitute for the terminal length of ureter may be necessary. The popular method is the bladder flap technique first described by Ockerblad. Here, a flap of the bladder is reconstructed into a tubular structure and anastomosed to terminal end of the ureter. Stents are used almost universally because of the tendency of these flap procedures to form strictures. Transureteroureterostomy has been used successfully by other surgeons to bridge large lower ureteral defects.¹³ Ideally, both sides of the urinary tract should be free of infection, with no significant dilation of the diseased ureter, but the operation has been successful even when these criteria were not met. The terminal end of the damaged ureter is brought behind the posterior peritoneum, spatulated, and anastomosed obliquely to the contralateral ureter.

An isoperistaltic segment of ileum may also be used as ureteral replacement when the injury is extensive. One important principle is that of insuring adequate anastomoses at the ureteroileal and ileovesical junctions. The terminal portion of the ileal loop should never be anastomosed to the ureter, for the flow of urine from the larger to the smaller lumen is almost universally unsatisfactory. Reimplantation of the ileum into the bladder is almost always followed by gross



Fig. 2. Intravenous urogram showing left hydronephrosis and ureterovaginal fistula.

vesicoileal reflux and persistent urinary-tract infection.

Urinary diversion and ipsilateral nephrectomy or ureteral ligation are reserved for the severely injured ureter. Here, the surgical approach demands careful assessment of the patient's age, clinical condition, primary disease, and function of the contralateral kidney. Whenever possible, functioning renal tissue is conserved.

Illustrative Case Report

A 39-year-old white woman underwent abdominal hysterectomy because of a ruptured ovarian cyst and chronic pelvic inflammatory disease. No surgical complications were encountered. On the day following operation pain was felt in the left flank, and later urinary leakage through the vagina was noted. Intravenous urography (Fig. 2) demonstrated left hydronephrosis with dilation extending well down into the bony pelvis. Retrograde ureterography (Fig. 3) disclosed a ureteral obstruction about 3 cm proximal to the bladder. Five weeks following hysterectomy the left lower ureter was explored extraperitoneally, a fistula due to partial ligation of the ureter at the vaginal cuff having been established. The fibrotic segment of the



Fig. 3. Retrograde ureterogram showing left lower ureteral obstruction and ureterovaginal fistula.

ureter, about 1 cm in length at the site of the fistula, was resected. The free ends of the ureter were then spatulated and rejoined. An internal stenting polyvinyl catheter, No. 6 French, was passed from the renal pelvis through the site of ureteral reanastomosis down into the bladder.

Drainage through a Foley urethral catheter was also instituted. The stent was left in place for 18 days, and upon its removal normal renal function, with no evidence of leakage or residual hydronephrosis, was demonstrated by intravenous urography. On follow-up visits the urine remained uninfected, renal function was shown by urography to be preserved (Fig. 4), and the patient had no further urologic complaints.

Summary

Trauma to the ureter, particularly of external origin, is uncommon. Internal injury of the ureter is usually the result of operations upon the colon or internal genital organs, or injudicious ureteral instrumentation. Congenital anomalies, neoplasia, obstruction, infection, and previous surgery or irradiation add to ureteral injury.

The diagnosis and localization of ureteral



Fig. 4. Postoperative intravenous urogram showing normal left urinary tract.

injuries require the intelligent use of available urologic radiographic techniques. Recognition of ureteral injury at the time of operation affords the opportunity for immediate repair, while subsequent definition of injury offers an opportunity for primary repair without interval urinary diversion procedures. Primary repair is favored, and reconstructive techniques are preferred.

Surgical management must be individualized according to the type, extent, location, and duration of injury, as well as attendant considerations such as contralateral renal function, the general status of the patient, and function of the lower urinary tract.

Internal stenting is preferred in uninfected ureteral injuries repaired primarily, while external stenting affords an opportunity for accurate measurement of renal functional capacity. Urinary diversion or ipsilateral renal ablation should be considered only when primary repair of ureteral injuries is not feasible. Excellent results of primary ure-

teral repair may be anticipated in uncomplicated cases.

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Animals which feed grossly, as tame ducks, hogs, etc. are neither so easily digested nor form such wholesome nourishment as others. No animal can be wholesome which does not take sufficient exercise. Most of our stalled cattle are crammed with gross food, but not allowed exercise nor free air; by which means they indeed grow fat, but their juices, not being properly prepared or assimilated, remain crude, and occasion indigestions, gross humors and oppression of the spirits, in those who feed upon them.—William Buchan: *Domestic Medicine, or a Treatise on the Prevention and Cure of Diseases by Regimen and Simple Medicine*, etc. Richard Folwell, 1799, p. 61.

Etiology and Diagnosis of Vertigo

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One of the most frequent complaints encountered in office practice today is dizziness or vertigo. Many patients are treated symptomatically, but the true cause of their difficulty remains undiagnosed. Either dizziness or vertigo may be a sign of disturbance in the end organ, central connections, or blood supply of the vestibular system, or its relationship to the visual or proprioceptive systems. The distinct analysis of the symptoms, scrupulous morphologic and functional examination of the vestibular system, and most important of all, the total medical consideration of the patient will aid in the diagnosis and enable the physician to treat his patients more intelligently.

A carefully taken history is vital in obtaining a correct diagnosis. First, the exact nature of the chief complaint must be determined. Otologic symptoms such as hearing loss, tinnitus, a sense of fullness in the ear, otorrhea, or otalgia should be noted. A history of recent head injury, or severe headaches, nausea, and vomiting accompanying neurologic symptoms and blackouts is significant. The ingestion of drugs which might cause an ototoxic reaction, vertigo, dizziness, nystagmus, or ataxia must be ruled out. The presence of a systemic disease such as diabetes, hypothyroidism, hypertension, hypotension, atherosclerosis, or the history of a recent febrile illness may be highly significant.

Definition and Variations

It is necessary to draw a clear line of distinction between true vertigo and the sensation of dizziness.

True vertigo can be defined as a subjective sensation of movement of the individual himself or surrounding objects. The movement is usually felt as identical to that following angular acceleration. It is accompanied by nystagmus and often by accessory vegetative

phenomena such as pallor, nausea, cold sweats, and vomiting. Occasionally a significant fall in blood pressure concomitantly may lead to impairment of consciousness and even convulsions. These signs, however, are usually indicative of a neurologic condition or disease of other organs.

Dizziness, in contrast to vertigo, is characterized as a feeling of light-headedness or faintness. There is usually no sensation of motion of objects and no nystagmus.

As a rule, the worse the vertigo, the closer the lesion to the peripheral labyrinth. The patient with a central lesion usually complains of dizziness rather than vertigo, and his symptoms are more prolonged than those associated with peripheral lesions.

Vertigo assumes many forms. It may be continuous over varying periods of time and independent of head and body motion, or it may be positional, occurring only when the head or body is in certain positions. It can also be transient, lasting only a few minutes, or paroxysmal, lasting from 30 minutes to two or three days.

A sudden total loss of vestibular function on one side usually produces a severe vertigo which gradually subsides after several weeks and then changes into a form associated with sudden movement. At no time does the patient experience positional vertigo.

Patients suffering a sudden partial loss of vestibular function have vertigo which gradually subsides after several weeks and becomes positional in type. The latter may persist for weeks or years.

Dizziness may be associated with gradual destruction of the labyrinth or with acute systemic infections. Patients who complain of continuous vertigo or dizziness for weeks or months usually have some underlying emotional disorder.

Nausea and vomiting may accompany disorders of the labyrinth, whereas vomiting alone may be indicative of central nervous system involvement. In patients having les-

ions of the posterior fossa, vegetative responses are usually absent. Vertigo that is preceded by nausea and vomiting is probably not of labyrinthine origin.

Ataxia in association with vertigo may be a sign of peripheral or cerebellar disease, but ataxia without vertigo does not indicate a disease of the labyrinth. Occipital headaches are more common in neurologic disorders.

Vertigo or dizziness of peripheral origin may be accompanied by otologic symptoms, such as hearing loss, tinnitus, a sense of fullness in the ear, otalgia, or otorrhea.

Neurologic symptoms such as diplegia, numbness of the face or extremities, blurred vision, diplopia, blindness, weakness or clumsiness, or difficulty in swallowing may accompany vertigo or dizziness of central origin.

Physical Examination

A complete examination of the ears, nose, and throat should serve as the basis of the entire investigation. Particular attention should be given to the nasopharynx, where hidden tumors may be the primary source of neurologic difficulty. The tympanic membranes should be inspected for evidence of middle-ear disease.

The neck should be examined for limitation of motion and carefully palpated for masses. Any abnormalities in the pulsation of the carotoid arteries should be carefully evaluated.

The blood pressure should be taken in both arms. The skull should be auscultated with a bell-type stethoscope to detect any bruits, particularly in patients who complain of tinnitus. No bruits are audible in the normal adult. The six critical points which should be auscultated are the eyes, the temporal bones, and the mastoid processes.

The patient should be examined for any deficits of the cranial nerves. The cerebellar function should also be carefully evaluated. The presence of asynergia, dysmetria, adiadochokinesis, or abnormal rebound phenomena indicates a disturbance in hemisphere function. Observation of the patient's posture while he is sitting, standing, and walking will help to rule out disorders of the vermis cerebelli.

Every patient should have a complete audiologic evaluation. This should include determination of pure-tone air and bone conduction thresholds, discrimination scores, tests for recruitment, and threshold fatigue of the eighth nerve.

The patient is then observed for spontaneous nystagmus on both forward and lateral gaze. Nystagmus with both a quick and a slow component is considered vestibular in origin. If eye movements are pendular, the nystagmus is likely to be ocular in origin and is usually irrelevant to the vertigo.

Vestibular nystagmus may be in a horizontal, rotary, or vertical plane. Horizontal or rotary nystagmus is often seen in peripheral disease, whereas vertical nystagmus suggests a central lesion. In peripheral disease spontaneous nystagmus is almost always unidirectional, transient, and related to a recent lesion of the vestibular system. In central nervous system disease, spontaneous nystagmus is prolonged, it may be multidirectional, and it is not accompanied by vertigo. Thus, spontaneous nystagmus lasting for longer than 24 hours after a vertiginous attack has subsided is usually indicative of central nervous system disease.

Positional tests should be performed in all cases in order to determine the type of nystagmus and vertigo. Peripheral lesions are usually associated with a delay in the onset of both nystagmus and vertigo on positional testing; these symptoms are less than 60 seconds in duration and cannot be elicited after the test has been repeated several times. With central lesions, the onset of both nystagmus and vertigo is immediate, the duration is long, and they can be reproduced after repeating the test numerous times. An immediate onset of nystagmus in the absence of vertigo on testing suggests involvement of the fourth ventricle secondary to irritation of the vestibular nuclei.

Vestibular function should always be evaluated. The most convenient method of doing this is the cold water caloric stimulation test. Responses may be normal, hyperactive, or hypoactive. Hyperactivity is seen in neurotic patients and occasionally in association with lesions of the fastigial nucleus. Hypoactivity

is indicative of a diseased vestibular system. The absence of any response suggests a lesion of the vestibular nerve or central vestibular pathways. Peripheral disease will not completely destroy the vestibular end organ except in transverse fractures of the temporal bone, suppurative labyrinthitis, or hemorrhage into the labyrinth, as seen in some cases of leukemia. In peripheral disease the direction of nystagmoid movements is always predictable following caloric stimulation. With central lesions, however, stimulation may produce an inverted or perverted nystagmus.

Etiologic Diagnosis

I. Peripheral labyrinth or end organ

A. *Toxic labyrinthitis*: This is the most common cause of a single attack of vertigo. The attack lasts a day or two and then gradually subsides. There is no associated deafness or tinnitus. Responses to caloric stimulation tests are normal. This condition is usually due to a toxic reaction to infection or drugs.

B. *Viral labyrinthitis*: The patient experiences a sudden partial or total loss of hearing in the involved ear, accompanied by tinnitus. There may also be a sudden onset of vertigo which gradually subsides over a period of days or weeks. Recovery from the hearing loss may be partial or complete. No spontaneous or positional nystagmus is present. Caloric test responses are not characteristic.

C. *Benign positional vertigo (peripheral type)*: The patient experiences sudden vertigo on changing to certain body positions. There is no history of hearing loss or tinnitus and no spontaneous nystagmus. On positional testing the patient experiences vertigo with a rotary nystagmus after a delay of 2 to 10 seconds. The vertigo lasts 5 to 30 seconds, is always fixed in direction, and cannot be reproduced after the test has been repeated several times. Caloric test results are usually normal. This condition is often seen in association with chronic otitis media, during the first week following stapedectomy, in mumps labyrinthitis, during the course of treatment for Meniere's disease with ultra sound, and with longitudinal fractures of the

temporal bone. In 50% of the cases the cause is unknown.

D. *Meniere's disease*: There is a sudden onset of vertigo of several minutes' duration, accompanied by hearing loss, poor discrimination of sounds, and tinnitus. Patients often experience a feeling of fullness in the ear, and tinnitus may change from a hissing to a roaring sound. In the early course of the disease there is a gradual improvement in both hearing and discrimination following the attack. Spontaneous nystagmus is noted only during an attack, and there is no positional nystagmus or vertigo. During the early course of the disease the caloric test responses are normal, but as the disease progresses they become hypoactive, indicating a disorder of the vestibular system.

E. *Lermoyz's syndrome*: This syndrome differs from Meniere's disease in that the onset of hearing loss and tinnitus precedes the attacks of vertigo.

F. *Cochlear hydrops*: The patient experiences fluctuations in hearing and tinnitus, but no vertigo or sensation of fullness in the ear. The condition may develop into Meniere's disease.

G. *Otolithic catastrophe*: In this situation vertigo strikes suddenly, with no premonitory symptoms, nausea or vomiting, and frequently causes the patient to slump to the floor. Attacks usually last less than a minute and recovery is almost always immediate. No hearing loss or tinnitus is experienced.

H. *Total loss of labyrinthine function*: This condition may result from hemorrhage into the inner ear, transverse fractures of the temporal bone, and suppurative labyrinthitis. The patient suddenly experiences total deafness and loss of vestibular function on the side of involvement. Symptoms also include severe vertigo which subsides after several weeks into a milder form, occurring only in response to sudden movement. Positional vertigo may also be present for several months.

I. *Chronic otitis media*: Vertigo may develop as the result of serous labyrinthitis, which is due to irritation and toxicity from an adjacent middle-ear infection. The signs and symptoms are similar to those in toxic

labyrinthitis and occasionally resemble those of viral labyrinthitis. Chronic otitis media may also cause a fistula to develop in the horizontal semicircular canal. Patients with this condition commonly have repeated episodes of vertigo of short duration which can be reproduced by compressing the external auditory meatus.

II. Lesions of the eighth nerve

A. *Vestibular neuronitis*: The patient usually has recurring episodes of vertigo for periods of several weeks to several months. There is no tinnitus or hearing loss. Spontaneous nystagmus may be seen only in the presence of vertigo. The patient usually has a decreased or absent response to caloric stimulation.

B. *Herpes zoster oticus*: The symptoms associated with this lesion are due to herpetic involvement of the geniculate ganglion (Ramsey-Hunt syndrome). The patient has vertigo and tinnitus associated with a vesicular herpetic eruption on the pinna and external auditory canal. Facial and auricular nerve palsy may also be noted.

C. *Acoustic neurinoma or cerebellopontine-angle tumor*: The patient usually experiences dizziness or vertigo, tinnitus, a slight to moderate degree of hearing loss, and a severe loss of the ability to discriminate between sounds. Larger tumors frequently result in corneal anesthesia followed by neurologic deficits of the sixth and seventh cranial nerves. Positional nystagmus is often present, and there may be no response to caloric stimulation tests in the involved ear. Increased cerebrospinal fluid pressure may cause headaches. The level of protein in the spinal fluid may also be elevated. In about can be demonstrated by x-ray. Arteriography can be demonstrated by x-ray. Arteriography and dye studies of the internal auditory canal are most helpful in making the diagnosis.

III. Lesions of the central nervous system

A. *Meningoencephalitis*: The patient may have a mild degree of dizziness or vertigo. Hearing and vestibular function are normal. Examination of the cerebrospinal fluid shows pleocytosis and increased protein.

B. *Brain-stem lesions*: Vertigo or dizziness may accompany lesions of the brain stem. Neurologic examination will usually reveal involvement of other cranial nerves. If spontaneous nystagmus is present and is vertical in direction, a collicular or peduncular lesion is indicated. A horizontal or rotary nystagmus points toward a more caudal lesion.

C. *Cerebellar lesions*: Vertigo or dizziness may occur in association with cerebellar lesions. Lesions of the vermis result in a loss of truncal equilibrium, poor posture, and a wide gait. The patient tends to fall backward in some instances. Bilateral asthenia may also be present. Lesions of the cerebellar hemispheres result in poor motor coordination of the extremities, a tendency to fall to the side of the lesion, and homolateral asthenia.

D. *Positional vertigo (central type)*: The patient experiences sudden vertigo on moving into certain body positions. There is no history of hearing loss or tinnitus. Spontaneous nystagmus is absent. The patient experiences vertigo with rotary nystagmus on positional testing. The nystagmus is immediate in onset, may be continuous as long as the position is maintained, is not always fixed in direction, and is reproducible each time the test is repeated. Caloric test responses are usually normal.

It is believed that this condition indicates involvement of the vestibular nuclei in the floor of the fourth ventricle. It could develop from arachnoiditis, encephalitis, brain abscess, injury to the fourth ventricle, the vermis cerebelli and the cervical cord, and sometimes follows electroshock therapy. Some investigators feel that hypertension, hypotension, drug ingestion, and systemic infections may also result in positional vertigo.

IV. Vascular lesions

A. *Disorders of the labile vascular system*: Dizziness or vertigo results from an inability of the cerebral circulation to adapt to changes in position and sudden movements. This condition is frequently made worse by fatigue or anxiety, and is transient in nature. A complete examination reveals no abnormalities.

B. Occlusion of the vestibulocochlear division of the internal auditory artery: The patient has a sudden onset of vertigo with loss of hearing for the high-frequency tones, and a high pitched tinnitus. During the first few weeks the vertigo decreases in severity and becomes positional in nature. The caloric test responses may be normal or indicate slightly hypoactive function in the involved ear.

C. Occlusion of the anterior vestibular artery; division of the internal auditory artery: There is an onset of severe vertigo, usually without auditory symptoms, which gradually subsides and eventually becomes positional in nature. The latter type may persist for weeks or years.

D. Occlusion of the internal auditory artery: There is a sudden onset of severe vertigo accompanied by total deafness and tinnitus in the involved ear. Caloric tests reveal no vestibular function. The vertigo gradually subsides and after several weeks is noted only on sudden movement. Positional vertigo may be present for several months.

E. Occlusion of the posterior inferior cerebellar artery: The patient, usually in the older age group, experiences a single attack of vertigo of one to six weeks' duration, which may be accompanied by headache, vomiting, hoarseness, or dysphasia. Examination may reveal an ataxic gait, Horner's syndrome, coolness of the skin and hypoalgesia of the face, paralysis of the vocal cord, and hypotonia of the extremities on the affected side. There may also be analgesia and coolness of the skin of the trunk and extremities on the opposite side. Spontaneous nystagmus may be noted, and the patient may have positional vertigo. The caloric tests will probably show decreased function on the affected side.

F. Basilar or vertebral artery insufficiency: The patient has recurrent episodes of vertigo lasting up to 15 minutes and sometimes accompanied by diplopia, faintness, loss of vision, dysphasia, dysarthria, monoplegia, hemiplegia or hemiparesis, ataxia, or headache. Usually there is a hearing loss, tinnitus, positional vertigo, and decreased response to caloric stimulation. In patients with basilar artery insufficiency, the above

symptoms may frequently be reproduced by turning the head, and symptoms may alternate from side to side.

G. Occlusion of the carotid artery: The patient usually has sudden episodes of dizziness with headache, slurred speech, hemiparesis, or hemiplegia.

H. Cervical syndrome: Dizziness or vertigo may be a result of compression of the vertebral or carotid arteries, the sympathetic trunk, or the first and third cervical nerves, with hyperextension of the neck secondary to cervical muscle spasm. Other symptoms may include pain in the neck, occiput, shoulder, or limited motion of the neck. Hearing loss and tinnitus are rare. Results of vestibular tests are usually normal. Symptoms may occur during positional testing, but if the head, neck, and shoulders remain aligned during the test, no symptoms will occur.

I. Subclavian steal syndrome: Episodes of vertigo or dizziness are precipitated by motion of the arm, and may be accompanied by weakness, fatigue, nausea, vomiting, pain in the shoulder, and low blood pressure in the involved extremity. This symptom complex is caused by occlusion or stricture of the subclavian artery proximal to the origin of the vertebral artery.

V. Systemic diseases

A. Blood disorders: Vertigo or dizziness with tinnitus is sometimes associated with anemia, sickle-cell disease, or polycythemia.

B. Multiple sclerosis: Positional nystagmus is seen in about 90% of cases of multiple sclerosis; about 65% of the patients have positional vertigo of the central type. In some cases, involvement of the vestibular nuclei may be the first symptom. The diagnosis is made on the basis of a variety of neurologic symptoms and signs, involving different structures at different times, and occurring in exacerbations and remissions. The gamma globulin level in the cerebrospinal fluid is elevated in approximately 65% of the patients.

C. Hypoglycemia: In hypoglycemic states, vertigo or dizziness is usually accompanied by nervousness, headache, sweating, pallor, rapid pulse, nausea, and vomiting.

D. *Migraine*: Vertigo may be the forerunner of an attack of migraine. It usually occurs several hours prior to the appearance of pain as a result of localized constriction of the cerebral arteries.

E. *Epilepsy*: Convulsions beginning with an aura of dizziness or vertigo are not uncommon, and have been shown to occur in response to stimulation of the interparietal sulcus.

F. *Vitamin deficiencies*: Dizziness or vertigo may accompany certain nutritional deficiencies, such as pellagra, which affect the central nervous system.

G. *Overdosage of vitamins*: Patients maintained on excessive amounts of vitamin A may have vertigo or dizziness as a manifestation of toxicity.

H. *Drugs*: Vertigo or dizziness may develop in some patients who have taken antihistamines, alcohol, barbiturates, meperidine hydrochloride (Demerol) or morphine. Salicylates and quinine may also produce dizziness or vertigo, accompanied by tinnitus and hearing loss. On withdrawal of the offending drug, the symptoms subside. The hearing loss produced by salicylates will disappear, but that resulting from quinine toxicity may be permanent. Streptomycin may cause vertigo, sometimes followed by hearing loss, due to permanent damage to the eighth nerve.

I. *Allergy*: Imbalance of the autonomic nervous system usually due to certain foods, may result in vertigo or dizziness. These symptoms are often accompanied by specific cravings, gastric distress (especially bloating), nuchal rigidity, periods of drowsiness after meals, and such nocturnal mani-

festations as headaches, coughing episodes, itching, and at times insomnia.

VI. *Menopause*: Attacks of vertigo sometimes occur during the menopause. The reason is unknown.

VII. *Psychogenic disorders*

Patients with these disorders complain of continuous dizziness or vertigo for periods of weeks or months in the absence of organic abnormalities.

Conclusion

Although it is fully recognized that a complete neurologic examination is not always possible in patients complaining of dizziness or vertigo, it is hoped that the material presented in this discussion will enable the physician to gain a more accurate clinical impression of these cases in order to direct the patient to treatment or further study.

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In a word, exercise without doors, in one shape or another, is absolutely necessary to health. Those who neglect it, though they may for a while drag out life, can hardly be said to enjoy it. Weak and effeminate, they languish for a few years, and some drop into an untimely grave.—William Buchan: *Domestic Medicine, or a Treatise on the Prevention and Cure of Diseases by Regimen and Simple Medicine*, etc. Philadelphia, Richard Folwell, 1799, p. 55

Continuing Education for the Internist in North Carolina

JAMES M. ALEXANDER, M.D.

CHARLOTTE

The rapid accumulation of new medical knowledge, equipment, and skill has created a problem of great importance and complexity for the practicing physician. It has been and always will be the responsibility of the individual physician to keep abreast of newly accumulated medical knowledge. The complexity of the problem can and will be lessened through the assistance of North Carolina medical educators.

Inter-University Continuing Education Program

The three North Carolina medical schools are fully aware of the problem of disseminating the vast amount of new medical information to practicing physicians. To help with this problem, the three schools—the University of North Carolina, Duke University, and the Bowman Gray School of Medicine—have established a coordinated program known as the Inter-University Continuing Education program.

The purpose and objective of the present proposal shall be to develop a coordinated approach to continuing education among the three medical schools through joint planning, participation, and sponsorship of appropriate programs; and through collaboration with the consumer as represented by the Medical Society of the State of North Carolina, the Academy of General Practice, and various specialty societies. It is hoped to develop a more adequate and better balanced program of courses and other educational services.

Use of the combined resources of the three institutions and coordinated planning will avoid diffusion and overlapping of effort and make possible more adequate programs based on need and desire of physicians.¹

In response to a request from the Inter-University Continuing Education Committee, Dr. Monroe T. Gilmour, North Carolina governor of the American College of Physicians (ACP), appointed a Committee on Continuing Education* to work closely with the Joint

Committee from the three medical schools. Together these committees will strive to develop an adequate educational program to serve the internists of this state.

The ACP committee realizes the great opportunities, responsibilities, and challenges this assignment offers, but to accomplish the designed purpose will require the united effort of all internists. With their understanding, help, and cooperation our complex problem will be solved more easily.

Organizations for Internists

Currently, North Carolina internists have three state meetings for educational purposes: (1) the American College of Physicians, (2) the North Carolina Society of Internal Medicine, and (3) the Section on Internal Medicine of the Medical Society of the State of North Carolina.

The ACP is the logical body, since its prime function is educational, to take the leadership in continuing education for the internist at the state and local levels. The membership of the College, the North Carolina Society of Internal Medicine, and those attending the Section on Internal Medicine of the State Society are almost identical, so there should be no conflict of interest. Our sole purpose should be to strengthen, coordinate, and improve the scientific programs of these societies and to establish other educational opportunities for the joint membership.

*ACP Committee on Continuing Education: Monroe T. Gilmour, M. D., North Carolina Governor of ACP, Charlotte; James M. Alexander, chairman, Charlotte; Kenneth D. Weeks, M. D., Rocky Mount; W. Reece Berryhill, M.D., professor of medicine and dean emeritus, University of North Carolina School of Medicine, Chapel Hill; Ernest Yount, M.D., professor of medicine and chairman of the Department of Medicine, Bowman Gray School of Medicine, Winston-Salem; Joseph B. Stevens, M.D., Greensboro; James T. Littlejohn, M.D., Asheville; Newton G. Pritchett, M.D., Raleigh; Samuel E. Warshauer, M.D., Wilmington; Herbert C. Sieker, professor of medicine and assistant dean, Duke University School of Medicine, Durham.

We all realize that our state and county societies are the official organization through which third parties will work. So we, the internists, must take a new look at these organizations: our future depends on it. We must become active in them and have representatives at the policy-making level.

To accomplish our educational goal will require some changes. First, the meeting date of the State Society should be changed in order to avoid conflicts with national meetings. Many of our members, especially those in academic medicine, have been unable to attend the State Meeting because of such conflicts.

This year, for the first time, the December meeting of the ACP was lengthened from a half day to a day and a half. The program committee, under the chairmanship of Dr. Kenneth D. Weeks, succeeded in arranging a timely, stimulating, and practical program.

The Inter-University Continuing Education Committee expects to plan a series of courses on important subjects, assigning responsibility for specific courses to the three medical schools. This committee seeks the advice of the ACP in planning courses for internists.

Another possibility being considered is the provision of a monthly bibliography, perhaps through the NORTH CAROLINA MEDICAL JOURNAL, of pertinent current literature. For a small fee physicians would be able to secure photostatic copies of desired articles from the three medical schools.

Already planned for the current year is participation by the Duke and Bowman Gray medical schools in the two-way radio conference program inaugurated in 1961 by the University of North Carolina.

Still other possibilities under consideration are telephone consultations on problem cases between practicing physicians and designated specialists at each of the schools; and postgraduate seminars conducted by the schools which small groups of internists could attend on a rotating basis. By such means practicing physicians could become better acquainted with their academic colleagues and at the same time keep abreast with current medical knowledge.

The Role of the Community Hospital

Dr. Bernard Dryer^{*} observes that the "gap between scientific knowledge and its application grows wider each year," and gives three reasons for the phenomenon: "(1) the rapid advance in research; (2) the maldistribution of opportunities for continuing education; (3) educational inadequacies even in those places where opportunities do exist and patterns of educational organization and dissemination of knowledge which are not efficient in terms of physician-student needs."

This raises the question of whether continuing education might not be better based on the community hospital rather than the medical school. Dr. John Caughey of Western Reserve University, in describing the results of the Flexner Report and the rapid progress in medical science, made the following observations:

Today an influential, large and increasing segment of the medical school faculty is made up of scientists, usually with Ph.D. rather than M.D. training, who have no direct relation to community health services. And in the clinical departments there is a growing tendency for positions of major influence and responsibility to be awarded to physicians whose training and clinical experience have been obtained entirely within the university and its associated hospitals, in highly specialized residencies, research fellowships, and full-time staff positions. Many of these leaders in academic medicine have had no personal participation in community practice and too often they are not concerned about the problems of community health services.

The close association of the medical education with the university hospital and the progressive movement of the medical school scientist toward focus on laboratory research at the cellular and molecular levels have produced a situation in which academic medicine appears to be concerned only with limited aspects of health service and is progressively more isolated from community practice, whereas the expanding concept of health and the growing expectations of the public for comprehensive health care demand that physicians accept responsibility for an increasingly wide range of problems related to health.

The Joint Study Committee on Continuing Education^{*} reported in 1961: "It is believed

^{*}Composed of representatives from the American Medical Association, American Medical Colleges, American College of Physicians, American Academy of General Practice, American Academy of Pediatrics, American College of Obstetrics and Gynecology, and American College of Surgeons.

that the patients and their physicians are better served by post-graduate medical education which links the teaching center bed to the community hospital bed, leaving the laboratory bench free to advance toward frontiers rather than to become a center of a forum."⁵

This implies that the practicing physician should resume his role as teacher in the community hospital.⁶ In North Carolina the community hospital can and should assume a dominant role in continuing education. There are several urban hospitals in this state that can and should be designated as area centers for postgraduate education. These hospitals should develop training programs second to none. This can be accomplished with the encouragement, cooperation, and assistance of the three medical schools.

Such a movement would help bring into balance the total medical educational program. It would bring to North Carolina additional doctors for postgraduate training, thereby increasing the number of physicians who will locate in the state. (Surveys show that doctors are more likely to locate in the area where they received their residency training rather than where they attended medical school.)

In order to establish a teaching program, the governing board of the hospital will be required (1) to assume the additional financial responsibility; (2) to employ a full-time director of medical education; and (3) to select a teaching staff that meets rigid educational standards. By the same token, the hospital staff must be willing to teach and be governed by strict regulations. The power to implement rules must be vested in the department heads, and there must be continuity of authority. A hospital that demon-

strates its willingness and ability to conduct a teaching program under these rules should have little trouble in securing the cooperation and assistance of the university centers.

Such cooperation is essential to the success of teaching programs in community hospitals. The exchange of residents between the two types of institutions would assure a high quality of residents in the community hospital and give the university hospital resident the benefit of clinical experience in a community hospital. Such an exchange would help keep the program in balance and assure the individual patient of the best available medical care. The urban teaching hospital should, in turn, assist the smaller community hospital with their educational programs.

Summary

The problem of disseminating the vast amount of new medical knowledge can best be resolved through joint planning, cooperation, and coordination of the efforts of all the medical educators, research scientists, and practicing physicians in North Carolina. Together we can close the gap between the latest medical knowledge and the application of this knowledge to medical practice.

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But the most afflicting of all diseases which attack the studious is the hypochondriac. . . . they live in the constant dread of death, and are continually in search of relief from medicine, where it is not to be found.—William Buchan: *Domestic Medicine, or a Treatise on the Prevention and Cure of Diseases by Regimen and Simple Medicine*, etc. Philadelphia, Richard Folwell, 1799, p. 57.

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OCCUPATIONAL MEDICINE

In this issue an article carries pertinent views of occupational medicine. Automation, a booming economy, and requirements of our armed forces have created greater esteem for better educational and physical standards. Industry sponsors remedial classes and controlled speed-reading sessions in many areas. More interesting and diversified work is constantly devised, and with automation, more leisure for the individual is allowed.

Complicated medical decisions become the

justified concern of employees, labor unions, and industry. Often honest opinions are sharply divided among physicians about some disabilities, especially those concerning aggravation of pre-existing disease. Several hundred physicians were queried on the effect of strenuous physical exertion or emotional disturbances on the heart. They were divided almost equally as to the existence of a relationship between strenuous work and a subsequent myocardial infarction. They favored emotional factors as a greater precipitating cause. Again they were divided on whether a permanent partial disability exists after an employee has recovered from myocardial infarction and returns to work symptom-free.

With the attractive temptation of litigation, the shocking benevolence of some juries, and the adaptable consciences of a few physicians, the peril becomes great that industrial compensation may be reduced to sickness insurance.

Every conscientious physician is vitally concerned with the employment and re-employment of the partially disabled. Dr. Batielli's discussion of the employability, liability, and health maintenance service is excellent and timely. It is appropriate reading for all physicians who treat patients.

E.W.F.

* * *

ENDEMIC GOITER AND DR. BUCHAN

In the filler which appears on page 48 of this issue, Dr. Buchan gives his view of the cause of endemic goiter. Since he wrote somewhere between 180 and 197 years ago, one may forgive him for not discussing the prime role of iodine in that disease, especially since it was only in recent years that the part played by iodine has been clarified to some extent. But Buchan's thoughts allow us to consider two related matters.

First, one might think initially that had Buchan and others of past centuries only recognized the effects of iodine deficiency, endemic goiter would have been understood. Indeed, it does appear that iodine deficiency is a major factor in endemic goiter. Less well known is the likelihood that decreased intake of iodine is not the whole story, at least in



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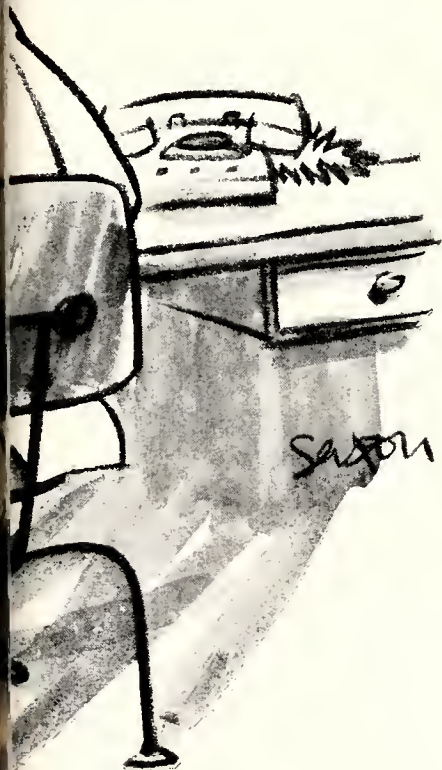
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some places. Goitrogenic substances in the environment, their effects intensified by local conditions and customs—for example, eating a lot of cabbage because it grows in a given place—are probably important in more than one locality. Inborn metabolic errors may disrupt iodine metabolism and cause signs of iodine deficiency in large numbers of a given population. In a phrase, dietary iodine deficiency, pure and simple, is neither too pure nor too simple.

Second, Buchan's view reminds us that the *presence* of something attracts much more attention than the *absence* of something—this despite the fact that deficiency diseases are now recognized as very important. Consider how long something added to the body was thought to cause pellagra. More new and fashionable, think of the significance of inborn enzyme deficiencies now that means are available to recognize at least a few of them. With due respect to Dr. Norman Vincent Peale, we must emphasize the power of negative thinking in some medical circumstances at least.

* * *

THE URGE TO VIBRATE

Somewhere in the catalog of human appetites, well below hunger and somewhere to the side of love, is a wish to absorb vibration. Little is said of this desire in physiology, and one could probably find the receptors cataloged only in obscure transylvanian journals with just the titles translated. Despite the apparent lack of scholarly atten-

tion, any moderately perceptive person sees this urge all around.

Vibration of a mechanical sort probably first appeared in barber shops and massage parlors, allowing the well-heeled a pleasant shakedown for 75 cents to one dollar in the real money of the times. Then a few years ago stores and shopping centers blossomed forth with horses and, as things grew more modern (and more profitable), space ships, submarines and the like, which would shake a child for a short period for 5 to 10 cents, while the parent smiled happily at his own relief from tugging and shin-kicking. Since the kids enjoyed this oscillation so much, the parents began to think there was something in it, and before long the same places had little platforms which would vibrate one's feet for a while for a small sum. Not too long thereafter motels and hotels began to feature beds which would simulate a mild earthquake for 25 to 50 cents for 15 minutes. The side effects of this treatment are too numerous to catalog, ranging from simulated drunkenness to the cure of that affliction. All these manifestations, being commercially successful, establish beyond doubt and without benefit of a "t" test the existence of vibratory lust.

The medical profession has taken little advantage of this therapeutic modality. People at large have recognized its value for eons, bouncing babies on knees to bring on contentment and sleep. Physicians have been willing to shake, rattle and roll for diagnostic ends, but not in treatment. Perhaps a new specialty is waiting for birth.

Water takes up parts of most bodies with which it comes into contact; by this means, it is often impregnated with metals or minerals of a hurtful or poisonous nature. Hence the inhabitants of some hilly countries have peculiar diseases, which in all probability proceed from the water. Thus the people who live near the Alps in Switzerland, and the inhabitants of the Peak of Derby, in England, have large tumours or wens in their necks. This disease is generally imputed to the snow-water; but it is rather owing to the minerals in the mountains through which the waters pass.—William Buchan: Domestic Medicine, or a Treatise on the Prevention and Cure of Diseases by Regimen and Simple Medicine, etc. Philadelphia, Richard Folwell, 1799, p. 63.

The President's Message

EDUCATION FOR QUALITY MEDICAL CARE

It is well said that the quality of medical care is a primary concern of doctors of medicine. There are many avenues leading to the provision of quality medical care. I have said before that *quality* of medical care is paramount, and I will repeat it again, and again, and again.

It would seem that the quality of education of the physician and his continuing education is a basic determinant in the ultimate provision of quality medical care for the people. And the same may be said regarding the education of those who are allied with medicine in the provision of medical care. This discussion will be limited to the education of physicians, and more particularly to the graduate education of physicians.

The physician, whether he is of town or gown, has inherited a concept of Aesculapius: that one must constantly learn, and one must teach others what he has learned, so that his fellow mortals may enjoy a state of optimal health.

Rising Standards of Excellence

The American Medical Association, the Medical Society of the State of North Carolina, and your personal physicians have an intense interest in the promotion of quality medical education today and tomorrow. The principal motive in the founding of the American Medical Association was a concern for the character and standards of medical education and thus for the qualifications of future physicians. Twice in the twentieth century the AMA has requested a survey of the state of medical education and has sought recommendations for changes to insure increasing excellence. In the first decade of this century the AMA took advantage of the interest in education for the learned professions and requested a study of the medical schools of the nation. The report of this study, known as the Flexner Report, was

wholeheartedly supported by the AMA and had a profound effect upon the development of American medical education, and therefore upon the medical care of our citizens.

In the half a century since the Flexner Report was made, a system of graduate medical education has become established and now constitutes the larger half of the formal education of the physician. For any learned profession there are but two alternatives for establishing standards of practice and education. Responsibility can be assumed by Society as a whole, operating through government, or it can be assumed by the organized profession through voluntarily accepted self-discipline.

When Flexner conducted his inquiries into medical education, the public was little concerned; now it is deeply concerned. The informed public is aware of the revolutionary developments in medical knowledge, of the dramatic advances in surgical skills, and of the new vaccines and so-called miracle drugs. Knowing all this, Society expresses its grateful appreciation by spending more money on medical services and supporting medical research which it confidently expects to lead to greater medical achievements.

After the M.D. Degree

Medical knowledge has grown so rapidly that no single practitioner can safely rely upon what he learned as a student or consider his own resources adequate for rendering optimal patient care. It is widely agreed that for a physician to remain highly competent, his education must not terminate with his residency training but must continue as long as he practices.

The medical student's involvement in true medicine begins with his four undergraduate years in medical school. The M.D. degree once marked the end of formal education. Today, however, it comes about half-way along the road. The receipt of this degree entitles the holder to take the state medical board examinations and upon successful

Adapted from an address presented before the North Carolina Public Health Association, Winston-Salem, October 6, 1966.

completion of the examinations to practice in the given states.

The typical young physician today now spends a year as an intern and three, four, or even more years as a resident, and possibly a year or two in sponsored practice before his colleagues, particularly those of the specialty boards, consider that he has completed his formal medical education.

Since the Flexner Report appeared we have tended to emphasize basic education in medical science, leaving most of the practical, hospital experience for the graduate period. With a range of student quality extending from good to excellent—and may I remind you that competition for admission eliminates candidates of indifferent quality—all medical schools turn out graduates who have the basic preparation necessary for specialization in any branch of medicine.

Today what has been termed undergraduate medical education is generally concentrated in fewer than 100 schools of medicine, whereas internships are offered in about 800 approved teaching hospitals. In general, internships are currently divided into three types. The original or rotating type provides about 12 to 24 months of experience in medicine, surgery, pediatrics, and obstetrics-gynecology, or one of the other fields of medicine. In recent years two additional types of internships have developed. One is called the straight internship. Another somewhat resembles a rotating internship, but provides training in two or three fields and frequently lasts from one to two years.

The typical medical school graduate now follows his internship with three or more years of residency training. In 1965 about 1300 hospitals in the United States offered residency programs.

As the period of formal training is extended, one questions whether it has not already been extended so far as to reduce the number of young people willing to undertake the long period of preparation. The problem is both practical and economic. It should be further pointed out that certain developments in recent years have caused many of our bright young men and women to avoid the medical field.

Demands and Expectations

We are confronted with certain expectations and demands. Few citizens have the knowledge to enable them to make valid distinctions between good medical care and inferior services. Often they demand what they *think* is "the best." The need for health care is increased and in some ways modified by the changing composition of the population. We have noted in recent surveys that people over 65 account for almost 10% of the total population. Without question, they will account for more than 10% in the future, as we increase our longevity.

Medical leaders in North Carolina share with leaders in other areas the great vision—a vision of future possibilities, the possibilities of more widespread and more properly applied preventive care. We hope for health prevention and protection, and at the same time we hope for the cure of disease. We hope to eradicate those diseases which we can eradicate, to prevent those which we can prevent, and to provide the best treatment possible for those diseases which we cannot prevent or cure at the present time. The continuing rise in the expectations of the medical profession and of the public, therefore, must affect the educational directives of future physicians.

Regardless of what today may say about tomorrow, the goal of medical education is still the same as it was even a century ago: to educate physicians who have the will and the qualifications to offer excellent medical care to their patients. It should be pointed out that unless a person is motivated, unless he is willing to sacrifice a large portion of his youth and early adult life to arduous training, and unless he is willing to forego the privileges which are apparently considered to be the rights of man, that person might as well stay out of medicine.

Specialization and General Practice

Today no single physician has all the knowledge and skills necessary to provide his patients with what might be called optimal care. We say that specialization implies some division of responsibility. On the other hand, how does one divide a patient? The Creator put the patient in one package.

It is alarming that with the rise of specialization has come a decline in the number of physicians who devote themselves to continuing and comprehensive care of the whole patient. The general practitioner has been the backbone of medicine for many years. Certain deficiencies that may be ascribed to him are to a great extent offset by his intimate knowledge of his patients, the support he gives them, and the trust and confidence his services engender.

For some reason, the private personal physician is tending to vanish. In 1931, 84% of all physicians considered themselves to be general practitioners. Thirty years later the percentage was 45%. Five years after that it dropped to 37%. Today only about 15% of recent medical school graduates indicate an interest in general practice.

Recently there has been talk about a new category of physician. Possibly it is not a new category but only an upgrading of the general practitioner. What this physician will be called or what his category will be is indefinite. Regardless of what he is called, he must be knowledgeable, as are other physicians, about systems, organs and techniques; and yet at the same time, he must objectively concentrate his attention upon the whole man. This is the man—or woman—who lives today in a changing socio-economic pattern, who has frustrations; and we must not forget that these extra-medical factors produce an enormous impact upon the well-being or state of health of the individual.

There is reason to think that the treatment of a sick man by committee is not a proper approach to medicine. It is certainly possible for the patient to die while the committee is getting organized, while it has its

invocation, and while it formally recognizes the eminent specialists who compose it. Regardless of these somewhat philosophical comments, there will necessarily be changes in the pattern of so-called postgraduate education in medicine.

Some of what has been said is frankly taken from the recent Report of the Citizens Commission on Graduate Medical Education (the "Millis Report"). Proper obeisance having been made to a prime source, further acknowledgment of the theft of ideas or words will be omitted.

It is worth noting that the majority of the members of this commission, which was created by the American Medical Association, were not doctors of medicine, and that the report itself was simultaneously made available to the AMA and all other interested groups.

Conclusion

The North Carolina State Medical Society is concerned with providing the people of this state with the best possible quality medical care. It believes in and is supporting continuing education for physicians. The Society is pleased to participate in the North Carolina Regional Medical Program. It will always support movements to improve the quality of graduate education for physicians to the end that now and in the future they will be able to render to the people of North Carolina a high level of medical care. The Society has always supported this type of program, and it sees no reason to discontinue its support. It also finds no reason why, with the changing times, the Society itself will not lead in the promotion of that prime factor—*quality*.

FRANK W. JONES, M.D.

The abominable custom of filling the cellular membranes of animals with air, in order to make them appear fat, is every day practiced. This not only spoils the meat, and renders it unfit for keeping, but is such a dirty trick, that the very idea of it is sufficient to disgust a person of any delicacy at every thing which comes from the shambles. Who can bear the thought of eating meat which has been blown up with air from the lungs of a dirty fellow, perhaps labouring under the very worst of diseases.—William Buchan: Domestic Medicine, or a Treatise on the Prevention and Cure of Diseases by Regimen and Simple Medicine, etc. Philadelphia, Richard Folwell, 1799, p. 61.

Committees & Organizations

VENEREAL DISEASE CONTROL SECTION

DIVISION OF EPIDEMIOLOGY

NORTH CAROLINA STATE BOARD OF HEALTH

VENEREAL DISEASE EDUCATION

It is established that the education of professional and lay communities is essential to any effort to eradicate disease. Certainly these categories of people must be knowledgeable concerning the disease and the principle behind the eradication effort if they are to be expected to both support and participate in that effort and, with regard to the lay community, to act responsibly with respect to recognition, avoidance, and control of the disease ultimately to be eradicated. Such education is and has been an obvious part of programs designed to control and eradicate polio, malaria, tuberculosis, smallpox, and other dread diseases. In the North Carolina Venereal Disease Eradication Program this type of education is provided via seminars, instruction in the public schools, and community mobilization and education programs.

Venereal Disease Seminars

Venereal disease seminars are held primarily for the benefit of practicing physicians, public health directors and their staffs, and professional educators. The purpose of these seminars is : (1) to provide up-to-date medical information relative to diagnosis and treatment of venereal disease; (2) to enlighten seminar participants concerning the epidemiologic aspect of the Control Program, and to illustrate how epidemiology is a practical extension of general practice and public health; (3) to explain new and advanced educational, epidemiologic, and medical techniques now being utilized in the eradication effort; and (4) to explain the Control Program's educational format, both for public school instruction and community education, and to illustrate the method by which this format can be implemented. Six such seminars have been held this year in various locations across North Carolina.

Public School Education

It is an established fact that North Carolina's Venereal Disease problem is, to a large extent, centered in the teenage and young adult population. Last year (1965) 63.8% of the 13,917 cases of infectious syphilis and gonorrhea reported involved persons between the ages of 15 and 24. Why? The North Carolina teenager may not have been provided with sufficient and accurate information in order to protect himself against venereal disease. A recent sociologic survey pointed out that 64% of all teenagers tested acquired information on venereal disease from the peer group. This phenomenon has amounted to the wholesale distribution of misinformation on venereal disease. Yet even with such evidence as to the need for public school instruction in venereal disease, only 20% of North Carolina's high school students are now receiving routine instruction on this subject.

The goal, therefore, of the Venereal Disease Control Program is to expand venereal disease instruction in public schools to include 100% of all high school students. In an effort to achieve this goal, discussions are under way with the North Carolina Department of Public Instruction, and a tentative arrangement has been reached concerning the adoption of venereal disease instruction as a part of state-endorsed curricula. It is hoped that this objective can be achieved through a joint directive concerning this adoption by the State Department of Public Instruction and the State Board of Health to all school superintendents and principals. The directive will spell out the need for such instruction, the reasons behind its adoption, and the method of implementation. Thereafter, the state is to be divided into districts for the purpose of conducting teacher-workshops designed to thoroughly orient teachers in venereal disease, to provide manuals for instruction, and to provide a methodologic guide of instruction.

The concept of venereal disease education being proposed for adoption by North Carolina school system is relatively simple. It consists of the presentation of venereal disease as a communicable disease, like any oth-

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¹ Riese, J. A.; Amer. J. Gastroent. 28:541 (Nov.) 1957

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er communicable disease. It involves instruction in regular classroom sessions, preferably health and/or biology, and as an integral part of the existing curriculum, not as a special insert into the curriculum. It assumes that the instruction will be given by regular faculty members and that all aspects of the subject—historical, medical, epidemiologic, and sociologic—will be covered in depth. Finally, this concept assumes that instruction will be limited to venereal disease per se and not in association with sex or family life education.

The purpose behind this concept is to present a body of information about syphilis and gonorrhea sufficient to motivate the student as follows: (1) to be sufficiently concerned about these diseases to do what he can within the total framework of his own knowledge and behavior to avoid them; (2) if exposed, to recognize the possibility of infection, know what to do, and do it; and (3) as a responsible member of the community, to demand community action to halt the spread of these diseases.

This concept and purpose has been formally endorsed by the Auxiliary to the Medical Society of the State of North Carolina.

Community Mobilization and Awareness

This concept is relatively new to the North Carolina Venereal Disease Control Program. It might be more appropriately called community action to facilitate community awareness—awareness of the venereal disease problem, of the threat to community health and well-being it poses, and of its solution. It is the coordinated effort of responsible citizens committed to the creation, through awareness, of a communal attitude of intolerance toward venereal disease—not intolerance toward the person who becomes infected but toward the idea that these diseases should exist within any community. It is designed to create through local campaigns the attitude that venereal disease should no sooner be allowed to exist than polio, smallpox, or malaria. In essence, it is designed to create for the North Carolina Control Program a climate of opinion favorable to its operation and to stimulate the active participation of local, responsible citizens.

Community mobilization may be compared structurally to an old wagon wheel. The rim of the wheel represents continuity and the continuing nature which these programs will have in North Carolina. The spokes represent the health, medical, professional, and civic organizations that will initiate and carry through local awareness programs. The hub represents the coordinating agency that will direct local programs in accordance with a master schedule of events. In essence, community mobilization is local community action to solve a community problem, and clearly makes community health a community responsibility.

The community mobilization program now being considered in North Carolina involves the following: (1) the establishment of a venereal disease information center; (2) the creation of a speaker's bureau for public or private utilization; (3) the establishment of mass programs, seminars, and symposiums; (4) the erection of billboards; (5) window displays; (6) exhibits for lay, educational, and professional gatherings; (7) mass information mailings; (8) programs via the mass media; (9) and the institution of committees of community action. This program is now being implemented by local citizens in various North Carolina cities.

The concept of community mobilization has been endorsed by the state organization of the Auxiliary to the Medical Society of the State of North Carolina.

U. S. PUBLIC HEALTH SERVICE

The Public Health Service has published a fifth edition of the **Research Grants Index**, an annual publication containing scientific subject matter summaries of more than 17,000 research projects supported by the PHS during fiscal year 1965.

The **Index**, first issued for fiscal year 1961, enables scientists to identify other researchers in their own and related fields and to exchange information before research results appear in journal sources. The publication is produced by the Research Documentation Section, Division of Research Grants, National Institutes of Health, and is distributed to libraries of all PHS-grantee institutions.

The two-volume **Research Grants Index** (PHS Publication No. 925) is available to the public from the Superintendent of Documents, U. S. Government Printing Office, Washington, D. C. at \$13.75 for the set.

Bulletin Board

COMING MEETINGS

North Carolina Conference of County Medical Society Officers and Committeemen—The Carolina Hotel, Pinehurst, January 27-28.

1967 Atlanta Graduate Medical Assembly—Marriott Motor Hotel, Atlanta, Georgia, February 5-8, 1967.

North Carolina Conference on Rural Health—Queen Charlotte Hotel, Charlotte, March 10-11, 1967.

Duke Pediatric Seminar—Duke University Medical Center, Durham, March 14-16.

Greensboro Academy of Medicine, 20th Annual Symposium—Greensboro, March 30, 1967.

NEW MEMBERS OF THE STATE SOCIETY

Dr. David Herman Jones, Oph, 713 North St., Smithfield.
Dr. William Borden Abernethy, Pd, 318 South St., Gastonia.

Dr. Edward Mark Kelman, Path, Gaston Memorial Hospital, 401 N. Highland St., Gastonia.

Dr. Frederick George Wenzel, S, Medical Arts Building, 1600 N. Main St., Waynesville.

NEWS NOTES FROM THE UNIVERSITY OF NORTH CAROLINA SCHOOL OF MEDICINE

Dr. Stuart Bondurant, who attended UNC from 1946 to 1949, has taken a leave of absence from the Indiana University School of Medicine to become chief of the medical branch of the National Heart Institute's Heart-Myocardial Infarction Program. He received his medical degree from Duke University.

* * *

William L. Ivey, associate director for three years, has been appointed director of N. C. Memorial Hospital, the 425-bed teaching hospital for the University of North Carolina School of Medicine.

He succeeds Eugene B. Crawford, Jr., who resigned to become executive director of the Wilmington (Del.) Medical Center.

Ivey is an assistant professor in the UNC Department of Hospital Administration and a lecturer in the School of Business Administration.

* * *

Childhood chest infections, medical problems of the aged, kidney failure, heart disease, and female disorders were among the discussion topics when Western North Carolina physicians attended a series of medical meetings in Asheville and Morganton in September and October.

A Postgraduate Course in Medicine, consisting of six weekly meetings, was sponsored by the Buncombe County Medical Society in Asheville and the Burke County Medical Society in Morganton in cooperation with the University of North Carolina School of Medicine and the UNC Extension Division.

Depression and alcoholism were in the spotlight at UNC during a meeting of the North Carolina Neuropsychiatric Association.

A day-long scientific session on October 21 was climaxed by an after-dinner talk by Harry Golden of Charlotte, writer, editor, lecturer and philosopher.

Dr. Jack Durell from the Laboratory of Clinical Science at the National Institute of Mental Health; Dr. Jack Mendelson, Harvard University psychiatrist and director of the new Center for Research on Alcoholism at the National Institute of Mental Health; and Dr. Francis Braceland of Hartford, Conn., past president of the American Psychiatric Association, and editor of the American Journal of Psychiatry and associated with the Institute of Living, were the key speakers.

* * *

The results of a three-year study of handicapped children in Alamance County were reported in Columbus, Ohio, on October 22 by Dr. William P. Richardson, UNC professor of preventive medicine and assistant dean for continuation education, at the resident's Dinner of the Ohio Society for Children and Adults.

* * *

A new and basic explanation of blood clotting was presented to the National Academy of Sciences in Durham by Dr. John H. Ferguson, chairman of the Department of Physiology at the UNC School of Medicine. He reported on some new experiments dealing with an enzyme which plays a key role in the clotting of blood.

* * *

A molecule-splitting enzyme demonstrated for the first time in human tissue is believed to control a delicately balanced chemical process which determines the texture of the skin and the type of scar which forms when a wound heals.

Two University of North Carolina medical researchers reported in San Francisco, California, that they have measured an enzyme which keeps the production of new collagen in balance with the removal of old collagen—a process which goes on continually near the surface of the skin.

They suggested that many human ailments can occur when this delicate chemical process gets out of balance. These ailments include ugly scars, poor healing, bed sores and even ruptured blood vessels.

Dr. Erle E. Peacock, Jr., surgeon in charge of the Division of Plastic Surgery at the UNC School of Medicine, and William B. Riley of Chattanooga, Tennessee, a fourth-year medical student at UNC, reported to the American College of Surgeons that the enzyme they have measured is capable of splitting tough collagen molecules so the pieces can be carried away in body fluids.

* * *

The UNC Medical School's 1966-1967 series of two-way radio medical conferences began on October 11 with a statewide discussion of office microbiology.

The speaker was Dr. Janet J. Fischer, a specialist in internal medicine at the University of North Carolina School of Medicine here.

Broadcasts on Tuesdays are being relayed to medical groups in Albemarle, Burlington, Charlotte, Durham,

Goldsboro (Wayne County Memorial Hospital), Greensboro, High Point, Mount Airy, Rockingham, and Tarboro.

Rebroadcast on Thursdays are for groups in Goldsboro (Air Force Hospital), Kinston, Sanford, Smithfield, Washington, and Wilmington.

* * *

Dr. Louis G. Welt, chairman of the Department of Medicine at the UNC School of Medicine, has been elected chairman of the Scientific Advisory Board of the National Kidney Foundation.

* * *

Miss Myrl Ebert, librarian for UNC's Division of Health Affairs Library, is spending a month as a consultant to the medical library at the University of Saigon in South Vietnam.

She is the only woman in a group of American medical consultants assigned to a rejuvenation project at the University of Saigon Medical School.

The project is under the joint sponsorship of the Agency for International Development of the U. S. State Department and the American Medical Association.

* * *

David A. Rendleman of Salisbury has been elected president of the first-year class at the UNC School of Medicine.

Other officers are: vice president, W. Borden Hooks, Jr. of Tarboro; secretary, Dewey Dance of Fayetteville; and treasurer, Mrs. Christine O. Suberman of Raleigh.

NEWS NOTES FROM THE DUKE UNIVERSITY MEDICAL CENTER

Construction has begun on the first phase of a new rehabilitation facility at Duke University Medical Center.

The \$850,000 project is the first of three units that are being built to expand Duke's role in the growing field of rehabilitation.

Phase one, which will be located behind Baker House at the east end of the hospital, will house areas for the rehabilitation of surgical patients, speech and hearing diagnosis and therapy, orthodontic (teeth and jaws) therapy, and offices.

The work is financed by the North Carolina Medical Care Commission, the State Office of Vocational Rehabilitation, and Duke Medical Center.

* * *

A Duke University scientist has proposed a program for the rational use of non-living donors for the treatment of many types of clinical disease.

Dr. D. Bernard Amos has called for enabling legislation to permit a patient to bequeath an organ of his body for transplantation to another. The proposal was made recently in Oklahoma City at a hearing conducted by the U. S. Senate subcommittee on government research.

Dr. Amos urged further research to improve methods for the preservation of organs and emphasized the need for more adequate financing for the basic research involved in transplantation.

* * *

New hope looms for victims of cystic fibrosis, one of the most common and most serious health menaces of childhood, with the isolation by a Duke University researcher of a blood factor believed to be related to the disease.

Acting on a hunch based on a somewhat accidental discovery, Dr. Alexander Spock succeeded in freeing from the blood a serum factor which he has definitely linked to the faulty gene involved in cystic fibrosis.

The achievement has been hailed by investigators as the first significant development in CF in the last decade. It makes possible recognition by a blood test of the unwitting carriers of the defect, estimated at about 5% of the U. S. population.

The achievement makes it possible for the first time in the history of the disease to open the door to useful genetic counseling that can lead to prevention.

* * *

Outbreaks of tuberculosis occurring with alarming frequency on board U. S. Navy vessels might have been prevented had BCG vaccine been used on the victims when they enlisted, a Duke University microbiologist claims.

Describing naval recruits as an "especially high risk" group, Dr. David T. Smith said BCG—a controversial vaccine that has not been generally accepted in the United States though it has elsewhere—is a practical answer to the spread of the disease.

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from clinical tuberculosis for up to 10 years," he argues.

Dr. Smith is James B. Duke Professor of Microbiology, the former chairman of the department of preventive medicine, and a past president of the National Tuberculosis Association.

In a letter in the correspondence section of American Review of Respiratory Disease, Dr. Smith calls for widespread use of BCG in high risk groups. This includes the armed forces, especially naval recruits, "among whom a number of epidemics have occurred on shipboard."

NEWS NOTES FROM THE BOWMAN GRAY SCHOOL OF MEDICINE OF WAKE FOREST COLLEGE

Dr. Richard L. Burt has been appointed chairman of the Department of Obstetrics and Gynecology at the Bowman Gray School of Medicine. He was also named chief of obstetrics and gynecology at North Carolina Baptist Hospital.

He succeeds Dr. Frank R. Lock, who has headed the department for the past 25 years. Dr. Lock, who will continue as professor of obstetrics and gynecology, resigned the department chairmanship to devote more time to the development of the medical school's behavioral sciences program, which he initiated. He will also continue his activities in the areas of teaching, research, and patient care.

Dr. Burt, who was appointed to the Bowman Gray faculty in 1949 and was promoted to professor in 1960, was recently named director of the medical school's new Clinical Research Center. He has gained international prominence for his research on changes in body chemistry and problems of diabetes during pregnancy.

A 1938 graduate of Springfield College, Dr. Burt holds the M.S. and Ph.D. degrees from Brown University and the M.D. degree from Harvard Medical School.

* * *

A long-range plan to develop the Bowman Gray School of Medicine and North Carolina Baptist Hospital as a major stroke center has been initiated with the establishment of two new programs at the medical school.

The school has set up a clinical research unit for the study of cerebral vascular problems and has devised a program of special training for physicians in the diagnosis and treatment of cerebral vascular diseases.

Two federal grants, totaling more than \$660,000, have been awarded to the medical school by the National Institutes of Health to support the projects.

Directed by Dr. James F. Toole, professor and chairman of the Department of Neurology, the programs will be coordinated on an interdepartmental basis with faculty members from at least five departments participating.

Dr. Richard Janeway, instructor in neurology, serves as coordinator of the cerebral vascular research unit, through which studies are concentrated on the prevention, causes and treatment of diseases of the blood vessels serving the nervous system.

The training program, which will utilize the resources of North Carolina Baptist Hospital and Forsyth Memorial Hospital, is designed to provide two-to-six weeks of intensive training for practicing physicians in the newest methods of prevention, diagnosis, and treatment of cerebral vascular diseases. While the program is open to any physician who sees patients with these diseases, enrollment will be limited to two physicians each training period.

* * *

Faculty appointments for Dr. Robert D. Olson, assistant professor of otolaryngology, and Dr. Noel D. M. Lehner, instructor in laboratory animal medicine, were announced recently by Dr. Manson Meads, dean.

Dr. Olson, who has served for the past six years as assistant professor and assistant director of the University of Southern California's Center for the Study of Speech and Hearing, formerly held faculty positions at Northwestern University and Ohio University. A speech pathologist, he holds the B.A. degree from Ohio University and the Ph.D. degree from Northwestern University.

Dr. Lehner, who received the B.S. and D.V.M. degrees from the University of Illinois, recently completed two years of fellowship training in cardiovascular research and laboratory animal medicine at the Bowman Gray School of Medicine. His chief research interests involve studies on atherosclerosis.

* * *

Dr. William H. Boyce, professor of urology, was a guest speaker for the III International Congress of Nephrology which was held recently in Washington, D. C. He spoke on "The Renal Tubule in the Genesis of Renal Calculi."

* * *

Dr. Richard L. Burt, professor of obstetrics and gynecology, participated in the first International Symposium on Intra-Uterine Dangers to the Fetus Oct. 11-14 in Prague, Czechoslovakia. He presented a paper on "Pre-Diabetes and Diabetes Screening in Pregnancy."


* * *

Four members of the Bowman Gray faculty participated in the Clinical Congress of the American College of Surgeons Oct. 7-14 in San Francisco, Calif.

Dr. Richard T. Myers, associate professor of surgery and Dr. Felda Hightower, associate professor of surgery, presented a scientific movie on "One-Stage Transabdominal Total Colectomy and Ileostomy for Ulcerative Colitis." Other participants were Dr. John T.

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Hayes, professor of orthopedics and Dr. George Drach, resident in urology.

* * *

Dr. Frank C. Greiss, Jr., assistant professor of obstetrics and gynecology, presented a paper on "A Clinical Concept of Uterine Blood Flow during Pregnancy" at the Fourth District meeting of the American College of Obstetricians and Gynecologists in Atlanta, Ga.

* * *

Four members of the Bowman Gray faculty participated on the program for the 42nd annual meeting and scientific sessions of the American Heart Association Oct. 21-25 in New York City.

They were Dr. Margaret C. Conrad, assistant professor of physiology; Dr. Harold D. Green, professor and chairman of the Department of Physiology; Dr. Hugh B. Lofland Jr., associate professor of pathology; and Dr. Henry S. Miller Jr., assistant professor of medicine.

* * *

Dr. I. Meschan, professor and chairman of the Department of Radiology, presented the first annual Martin T. Macklin Memorial Lecture Oct. 28 at the U. S. Naval Hospital, Portsmouth, Va. He spoke on "The Role of the Radiologist in Evaluation of Renal Function."

* * *

Dr. Robert W. Prichard, professor of pathology, spoke

at a meeting of the American Association of Blood Banks Oct. 27 in Los Angeles, Calif. His topic was "Workshops for Inspectors."

* * *

Dr. R. Winston Roberts, professor of ophthalmology, participated in the annual meeting of the American Academy of Ophthalmology and Otolaryngology in Chicago, Ill. He taught a course on "Early Diagnosis of Glaucoma" and presented an exhibit on "Information Retrieval in the Study of Glaucoma."

* * *

Dr. Clark E. Vincent, professor of sociology and director of the medical school's Behavioral Sciences Center, participated in a symposium on Sex Education of the College Student Oct. 21 at Pennsylvania State University. His topic was "The Pregnant Single College Girl." Earlier in the month he spoke on "Society's Dilemma in Sex Education" at a Waukesha, Wis., seminar on Sex Education in Schools.

NORTH CAROLINA DEPARTMENT OF MENTAL HEALTH

The North Carolina Department of Mental Health has recently opened a new facility for treatment of blind, multihandicapped children at Butner.

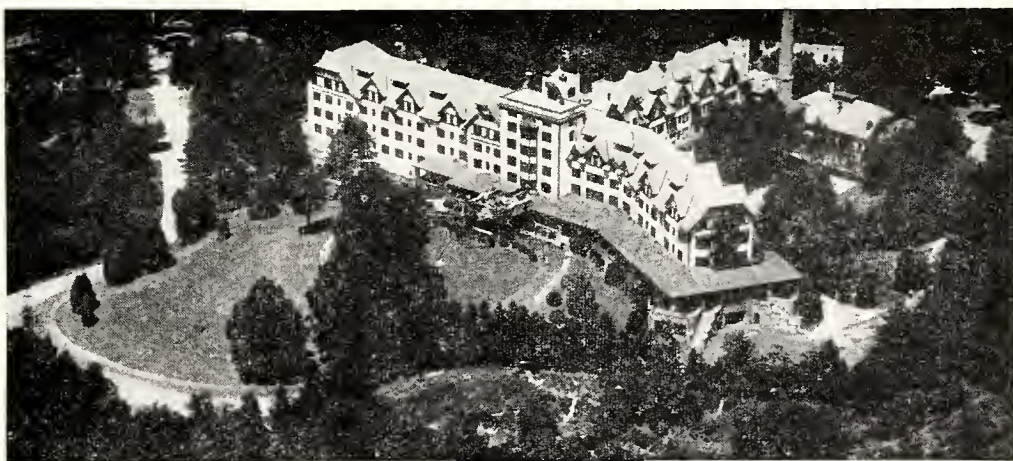
Located on the grounds of Murdoch Center for the mentally retarded the 100-bed unit will provide services

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for blind retardates with additional physical, mental, or emotional disabilities.

Ray Pope is the recently named director of the new unit.

Until now there has been no facility in North Carolina—public or private—designed specifically for this group of handicapped children. In fact, only a handful of such facilities exists within the entire United States.

An integral part of Murdoch Center, the new unit will provide training and other programs for trainable and educable children in the 6 to 18 year age group, and will serve the entire state. Since the physical facilities and program were designed for ambulatory children who can get around on their own, no semi- or non-ambulatory children will be admitted.

Others have had trial admissions at the Governor Morehead School for the Blind in Raleigh and at the state's four retardation centers.

Currently, about 50 applications for admission have been received from parents.

Constructed with funds appropriated by the 1963 General Assembly, the newly completed \$764,400 facility was designed by Harris and Pyne, Durham architects. Among its features are four living units each with 24 beds; four smaller "quiet rooms" for use by children having special problems; an indoor swimming

pool; gymnasium; eight classrooms; four day rooms; a music room; several outside covered areas for play and storage; and additional uncovered outdoor play areas.

Some eighty-two clinical personnel will staff the new facility in addition to clerical and maintenance personnel.

Full-time social workers, a physical and occupational therapist, nurses, a speech therapist, and special education teachers are needed.

A physician and clinical psychologist will be available on a part-time basis from Murdoch Center and the University of North Carolina in Chapel Hill.

NORTH CAROLINA STATE BOARD OF HEALTH

Persons responsible for the management of many millions of dollars for public health met at Wrightsville Beach on Nov. 9, for their annual conference. Five states, the District of Columbia, Puerto Rico and Virgin Islands were represented. Ben Eaton, Raleigh, director of the Administrative Services Division of the State Board of Health, was chairman for this year's meeting.

How program budgeting could be applied in North Carolina's state government programs was the concern of the North Carolina delegation attending the meeting.

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NORTH CAROLINA FOUNDATION FOR MENTAL HEALTH RESEARCH

The North Carolina Foundation for Mental Health Research, Inc. has announced the appointment of Dr. Peter N. Whitt of Raleigh as its new executive director.

Dr. Whitt came to the state recently from Syracuse, New York to become director of research for the North Carolina Department of Mental Health, a post in which he will continue.

The foundation was established in 1961 to support and promote scientific research studies and projects throughout all the mental health facilities operated by the State of North Carolina.

Melville Broughton, Jr., of Raleigh is president of the foundation and Mrs. Winifred T. Wells of Wallace is chairman of its 19-member board of directors.

NORTH CAROLINA PHYSICAL THERAPY ASSOCIATION

"Suggested Guidelines For Out-Of-Hospital Physical Therapy Services" have been completed by the North Carolina Physical Therapy Association. The guidelines were developed to assist those planning, providing, and utilizing physical therapy services in response to the increased demands for services, magnified by the federal legislation of 1965. Four areas of physical ther-

apy service are outlined: direct care, teaching, supervision, and consultation. A model contract, drawn up with legal advice, to provide physical therapy service by an independent contractor is included.

The North Carolina Physical Therapy Association, as well as other professional organizations, was requested by the State Board of Health to submit guidelines for their respective disciplines to be included as part of a comprehensive Home Health Services Manual. The manual is for use by agencies planning to participate in offering out-of-hospital services.

The Association received a grant from the State Board of Health to conduct a workshop on "Participation of Physical Therapists in the Implementation of Medicare In North Carolina" and to prepare the guidelines. The guidelines have been distributed to physical therapists registered and practicing in North Carolina, the state medical society, the hospital association, and other appropriate persons and organizations. Copies are available for \$1.00. Requests should be directed to the president, Mr. James Austin, Department of Physical Therapy, Baptist Hospital, Winston-Salem.

NEWS NOTE

Dr. Rachel Meschan, recently announced the opening of an office for the practice of Premarriage and Marriage Counseling at 2716 Bartram Road in Winston-Salem.

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AMERICAN MEDICAL ASSOCIATION

Milford O. Rouse, M.D., of Dallas, Texas, was chosen president-elect of the American Medical Association in June, 1966. He will take office as the Association's 122nd president in June, 1967, serving a one-year term.

Previous to his election, Dr. Rouse had served as speaker of the House of Delegates since June, 1963, and, prior to that, had been vice-speaker of the House for four years.

Dr. Rouse was born in Jacksonville, Texas, on August 10, 1902. Because his parents were Southern Baptist missionaries, he spent part of his boyhood in Brazil and Cuba.

Dr. Rouse received the B.A. and M.A. degrees from Baylor University and his M.D. degree from its College of Medicine, the latter in 1927. He interned at Fort Sam Houston Station Hospital in 1927-1928.

He has practiced in Dallas since 1928, specializing in gastroenterology. Since 1943 he has been clinical professor of medicine in the University of Texas Southwestern Medical School.

AMERICAN COLLEGE OF SURGEONS

Realizing the importance to the patient's welfare of the combined "Registry-Cancer Clinical Activities" program, the Commission on Cancer at its annual meeting in October, 1966, altered its voluntary hospital approval

(Bulletin Board continued on page 612)

Classified Advertisements

Pediatric practice available for follow up pediatrician mountain town-county fifty thousand population also drawing other areas. Three hospital town opening suitable two pediatricians with office available and take over arrangements. Marked urgency on this replacement. Write "Placement Service 14-25", P. O. Box 790, Raleigh, N. C. TF

New Film on Platelet Transfusion Therapy

A motion picture demonstrating a medical technique that is substantially reducing leukemia deaths due to hemorrhage has been released by the Acute Leukemia Task Force of the National Cancer Institute. The film, titled "Technique of Platelet Transfusion Therapy," was prepared as orientation material for blood bank personnel by the Task Force at the National Institutes of Health, U. S. Public Health Service.

The film presents a step-by-step demonstration by a hematology technician of the platelet separation process, and portrays a family's role in contributing to a leukemic child's well-being through platelet transfusions.

The 16-millimeter color production, running time 21.75 minutes, was made with assistance from the American Red Cross, the District of Columbia General Hospital, and the Clinical Center of the National Institutes of Health. Requests to borrow the film without charge may be addressed to the U. S. Public Health Service Audio-visual Facility, Atlanta, Georgia 30333.

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J. William Giesen, M.D.

Internist

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The Month in Washington

High on the list of health legislation to be considered by the new Congress convening January 10 are proposals to amend both the medicare and medicaid programs.

Proposed medicare amendments would extend the program to the disabled, include podiatrists' services, add out-patient drugs to Plan B, and authorize that billing for services of hospital-based physician specialists be put back under hospitals.

Sen. Russell B. Long, (D., La.), chairman of the Senate Finance Committee which handles medicare and medicaid legislation, is pushing a proposal designed to get physicians to prescribe drugs by generic terms for patients under federally-aided medical programs. Such an amendment died in a conference committee in the final days of the last Congress.

Amendments to limit federal expenditures under medicaid (Title XIX) are expected to get early consideration by the House Ways and Means Committee. The committee reached agreement on such legislation shortly before adjournment last year, but it was too late to get it through Congress.

One of the final pieces of legislation passed by Congress in 1966 authorizes liberalization of the Keogh law under which physicians get a tax break for savings put in qualified pension plans. The full amount of the \$2,500 annual maximum was made tax deductible. Only half of the amount was tax deductible under the original law.

Other health legislation approved by Congress in 1966 includes:

Group practice—authorizes federal mortgage guarantees for construction of non-profit group practice facilities.

Health services—authorizes the Office of Economic Opportunity (antipoverty) to make grants for comprehensive health services programs, including birth control.

Public health—authorizes (1) \$145 million, one-year extension of PHS programs, including \$125 million for project grants for categorical programs. States and the PHS

are given greater flexibility in spending the money among the various categories and including other "public health" projects; (2) extends the federal-aid vaccination program for three years; (3) provides for family health services for migratory workers.

Air pollution—authorizes a three-year, \$186 million extension of the federal anti-air pollution program and provides broader authority for air pollution control activities by localities.

Water pollution—authorizes a \$3.7 billion, four-year program for cleaning the nation's waterways. It includes initiation of a massive program for combatting pollution in major water basins.

Child care—prohibits sale of toys containing hazardous substances and strengthens existing law covering household hazardous substances; does not contain a disputed provision covering children's aspirin and other drug controls in the original legislation.

Narcotics—permits addicts charged with nonviolent crimes to choose hospital commitment instead of trial, if the authorities agree, or could be sentenced after trial to hospitals for rehabilitation.

Packaging—requires that over-the-counter drugs and grocery products bear labels clearly showing the contents, quantity, and manufacturer.

Mental health—amends original law to provide grants to assist in the establishment and initial operation of community mental health centers.

Research laboratory animals—provides for federal regulations covering transportation, purchase, sale, housing, care, handling and treatment of such animals.

Military medicare—amends existing law to provide for out-patient care in a physician's office and to include retired reservists and their dependents.

Allied health professions—authorizes \$105 million for a three-year program to train more medical technicians, therapists and other allied health workers.

* * *

The federal government has launched an extensive program to control and prevent alcoholism.

As initial steps, Health, Education and Welfare Director John W. Gardner established a National Center for the Prevention and Control of Alcoholism and appointed an 18-member National Advisory Committee on Alcoholism.

In announcing the program, Gardner stated its two major aims:

1. The immediate goal of making the best treatment and rehabilitation services available to those who need them now—through both the stimulation of existing resources and the development of new manpower and facilities.

2. The long-range goal of developing effective, practical, and acceptable methods of preventing alcoholism and excessive drinking in all their destructive forms and developing improved therapeutic techniques.

Milton Silverman, special assistant to the HEW assistant secretary for Health and Scientific Affairs, was named coordinator of the program and executive secretary of the advisory committee.

The National Center, will be active in a number of major areas including: basic research, clinical research, education and prevention, consultation and training, and support of local programs.

"It will encourage and support alcohol research in universities and research centers and it will also conduct studies in its own laboratories," Gardner said. "It will not provide treatment for alcoholics, but will concentrate on the support of research, training, and control programs.

"We realize that a program of this kind cannot stand alone. It needs widespread public understanding and support. We will work with organizations and institutions already making great contributions to the prevention and control of alcoholism. Our objective, in brief, is to mobilize public and professional efforts on the scale necessary to overcome the blight of alcoholism."

In Memoriam

Ralph Gordon Templeton, M.D.

Ralph Gordon Templeton was born in China Grove, North Carolina, August 9, 1916. He was educated in the China Grove schools, at the University of North Carolina

in pharmacy, and was graduated from the Duke University School of Medicine in 1942. Following an internship at the Duke University Medical Center, Dr. Templeton entered the United States Army and served until 1946, being discharged from service as a captain in the Medical Corps. He immediately entered the practice of medicine in Lenoir where he served faithfully and conscientiously until his death on July 4, 1966. He was chief of the medical staff at Blackwelder Hospital and was also an active member of the medical staff of Caldwell Memorial Hospital, where he previously held the post of chief of staff. For twenty years he was active in the affairs of the Caldwell County Medical Society, having served as president.

An exemplary citizen as well as a devoted physician, Ralph Templeton was past-president of the Lenoir Optimist Club, a member of the Masonic Lodge, and the American Academy of General Practice. A leader of St. Stephen's Lutheran Church, he had previously served on the church council and was chairman of the building fund committee. He was an enthusiastic member of the Advisory Development Committee for the Duke University Medical Center.

In 1937 he was married to the former Miss Janie Wilkie. Three daughters were born of this union: Mrs. Paul Chester, Roxanne, and Susan; and two sons Ralph, Jr., and Thomas.

Ralph Templeton was elected to the North Carolina Board of Medical Examiners in 1962 and served actively until the time of his death. In 1964 he was president of this group. A dedicated physician and citizen, he worked tirelessly and sacrificially in the care of the sick of his area and for the improvement of life for the citizens of his community and this state. The memory of his service to others, his dedication to family, medicine, church and community, his warm and sincere personality will long remain. Now, be it

Resolved, That the North Carolina Board of Medical Examiners, at its meeting on October 7, 1966, formally and solemnly recognize, with appreciation for his service to its cause, the loss of its member, colleague, and friend. Be it further

Resolved that a copy of this resolution be forwarded to his family, to the Caldwell County Medical Society, and the North Carolina Medical Journal.

Dow Awarded Contract for Artificial Kidney Research

The Dow Chemical Company has been granted a \$194,872 contract by the Public Health Service, Department of Health, Education and Welfare, to conduct research and development on improvements in design of an artificial kidney.

Under the contract the team of Dow research scientists will continue experimentation and testing of a capillary kidney concept which has been in progress for several years. This concept involves the use of tiny, hollow plastic fiber tubes to duplicate the function of the kidney to remove wastes from the blood. The tubes are assembled in "bundles" in a design which, if successfully put into practice, could provide an artificial kidney of small size, low cost and simplicity of operation.

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Abbreviations

C—Correspondence

BR—Book Reviews

C&O—Committees and Organizations

PP—President's Page

RT—Report on Trauma

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program with the provision that after January 1, 1967, no new "Registry only" programs will be approved; and that on January 1, 1968, approval of "Registry only" programs will be discontinued.

Those hospitals now having approval for "Registry only" and desiring to expand to meet the requirements for approval of a combined "Registry-Cancer Clinical Activities" program will be given technical and professional assistance from the staff of the Commission on Cancer and the Liaison Fellows in the hospital district.

Meeting the present minimum requirements for a cancer clinical activities program as listed in the Manual for Cancer Programs, 1966, should present no major problem when a well-functioning registry is in operation and the medical and administrative staff realize its value toward better patient care.

U. S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

The cooperation of physicians is requested in the referral of patients with the highly suspicious or proven diagnosis of a carotid body tumor. This study is being conducted at the Clinical Center of the National Institutes of Health by the National Cancer Institute and the National Institute of Arthritis and Metabolic Diseases. The purpose of this investigation is to relate histochemical evidence of catecholamine containing cells in carotid body tissue to excretion of catecholamines and their metabolites.

Patients admitted will be evaluated for definitive treatment. Upon completion of their study, the referring physician will be contacted concerning the indications for treatment and a cooperative decision made as to whether the treatment be best carried out at the Clinical Center or back in the hands of the referring physician.

Physicians interested in having their patients considered for admission to this study may write or telephone: Alfred S. Ketcham, M.D., Clinical Center, Room 10N-116 National Institutes of Health, Bethesda, Maryland 20014.

* * *

The cooperation of physicians is requested in the referral of patients for a study being conducted by the Endocrinology Branch of the National Cancer Institute at the Clinical Center, National Institutes of Health, Bethesda, Maryland.

Patients with early metastatic breast cancer are needed for study and treatment. Patients with diseases of the gonads or pituitary will be accepted for diagnosis and initiation of therapy.

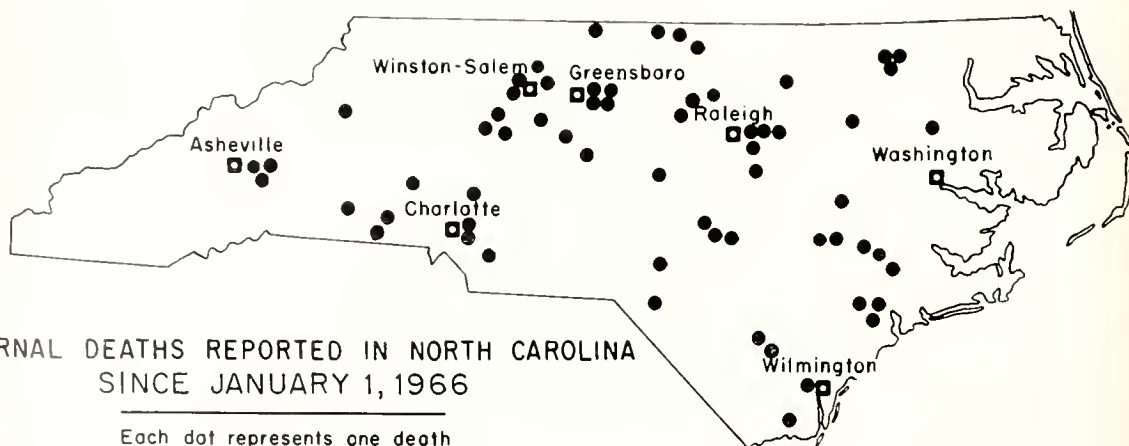
Physicians interested in having their patients considered for admission to this study may write or telephone: Mortimer B. Lipsett, M.D., or Griff T. Ross, M.D., Clinical Center, Room 12-N-204, National Institutes of Health, Bethesda, Maryland 20014.

* * *

A \$125,000 grant to the World Health Organization to help finance an international pilot study of schizophrenia has been announced by Dr. Stanley F. Yolles, Director, National Institute of Mental Health, U. S. Public Health Service. An additional \$250,000 in support by NIMH is planned over a three-year period. Other participating countries will support the project in varying amounts and the WHO will supply \$145,000 each year.

Scientists participating in the study will try to devise and to apply standard methods of identifying schizophrenics. They will attempt to agree on standard ways to describe the psychological and behavioral characteristics of schizophrenic patients, and for determining the effect that cultural and social differences have on the course of the disease.

The study will be conducted in eight countries. They are the United States, Russia, Denmark, Great Britain, Columbia, Nigeria, Nationalists China, and India.



MATERNAL DEATHS REPORTED IN NORTH CAROLINA
SINCE JANUARY 1, 1966

Each dot represents one death

